Patient Information

Name: Last_____________________________________First___________________________Birth Date:______/______/_________

Address:____City:___________________State:______ Zip:_____________ Sex: ☐M ☐F

Home Phone:_________________________ Mobile Phone #: _________________________ Social Security # _______-_____-______

Email address:_____________________________________ ☐ Please check box if, approved for PHI (Personal Health Information) use

Physician To Be Seen Today: ☐ Dr. A. Eli Gabayan ☐ Dr. Linnea Chap ☐ Dr. Jennifer Lang ☐ Dr. Ari Gabayan ☐ Dr. Patricia Gordon ☐ Dr. Steven O' Day ☐ Dr. Donald P. Lombardi

Reason For Today's Visit: ☐ New Patient Consult ☐ Follow-Up ☐ Infusion ☐ Blood Work ☐ Imaging ☐ Radiation Therapy

How did you hear about the Beverly Hills Cancer Center?
☐ Referring Doctor ☐ Family/Friend ☐ Internet ☐ Health Fair ☐ Saw an Ad ☐ Other
Name of Referrer or Location of Ad:____

PHYSICIANS ARE REQUIRED BY FEDERAL GOVT AND/OR THE STATE OF CA TO REQUEST AND DOCUMENT THE FOLLOWING INFORMATION
Race: ☐ **Asian Indian, Pakistani** ☐ **Black** ☐ **Chinese** ☐ **Filipino** ☐ **Hawaiian** ☐ **Hispanic** ☐ **Japanese** ☐ **Native American** ☐ **Korean** ☐ **Vietnamese** ☐ **White** ☐ **Other** ☐ **Decline to Answer**

Ethnicity: ☐ **Hispanic or Latino** ☐ **Non-Hispanic or Latino** ☐ **Decline to Answer**
PREFERRED LANGUAGE ____

Employer:____ Work Phone #:____________________________
Employer Address:____

Relative or Friend Contact Information:
In the event you are unavailable to be contacted by our office, please indicate with **Yes or No** any family member or friend that we are able to release any or all information relating to your medical condition.

1) Name:________________________________Relationship: ________________________Phone #: ____________________☐Y ☐N

2) Name:________________________________Relationship: ________________________Phone #: ____________________☐Y ☐N

3) Name:________________________________Relationship: ________________________Phone #: ____________________☐Y ☐N

Assignment of Benefits and Acknowledgement

The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to Beverly Hills Cancer Center of any insurance benefits otherwise payable to or on behalf of the undersigned for services rendered. It is understood by the undersigned that he/she is financially responsible for charges not fully satisfied by his/her insurance payment. This is to make you aware that your insurance company may deny payment for a multitude of reasons. Depending on your plan, your insurance can and may deny payments based on the coverage of your policy and may also leave you responsible for a certain portion. We do not know for certain until your insurance company is billed. Insurance companies do not guarantee payment until they have received your claim. If your claim is denied, Beverly Hills Cancer Center will resubmit the claim. After such resubmission, if the claim is still denied we will bill you for the procedure. The undersigned agrees to be personally and fully responsible for complete payment to Beverly Hills Cancer Center for all services and shall also be responsible for all attorneys' fees and collections costs incurred by Beverly Hills Cancer Center.

Print Name:___________________________________ **Signature:**______________________________ **Date:**_____________
Relationship if other than patient:____

PATIENT COORDINATOR COPY

Referring and Primary Care Physicians

Patient Name:____

Please list the names, addresses and phone numbers of other physicians that you are seeing.

This information is very important so that we can inform your physicians of your progress.

****Referring Physician**:____

Address:____

Phone:____

****Internist/Primary Care Physician:**____

Address:____

Phone:____

Other Physician:____

Address:____

Phone:____

Other Physician:____

Address:____

Phone:____

Other Physician:____

Address:____

Phone:____

PATIENT COORDINATOR COPY

Authorization for Release of Medical Records

I hereby authorize:____

To release the following information from my medical records: to Beverly Hills Cancer Center *OR* to ___________________

Patient Name: ____

Date of Birth: ___________/_____________/______________

Records Specifically Requested:

- ☐ Surgery Report(s)
- ☐ Pathology Report(s)
- ☐ Imaging Report(s) including X-Ray, CT, MRI, Nuclear Medicine
- ☐ Consultation Report including History & Physical
- ☐ Radiation Therapy Records (if any)
- ☐ Chemotherapy Records (if any)
- ☐ Most recent Follow-up record
- ☐ Other:____

Print Name:____

Patient Signature:____Date:_________/__________/_________

PATIENT COORDINATOR COPY

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ePRESCRIBE- AUTHORIZATION TO OBTAIN MEDICATION HISTORY

I, ____,

(Patient Name Printed Here)

*** Authorize Beverly Hills Cancer Center to download my medication history in order to facilitate electronic pharmacy prescriptions as may be prescribed by my physician.**

______________________________ ____

Date Patient/Responsible Party Signature

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Patient Medical History and Disclosure

Patient Name:____

Are you experiencing pain now? ☐ **No** ☐ **Yes** if Yes, location of the pain ______________________________________

Level of pain: (0 = No Pain, 10 = Severe Pain) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Past Medical History **(Please check all that apply)**

☐ Diabetes:_______________________________	☐ Stroke:_______________________________
☐ Asthma:_______________________________	☐ Emphysema:_______________________________
☐ Blood Clots:_______________________________	☐ Blood Transfusions:_______________________________
☐ High Blood Pressure:_______________________________	☐ Heart Disease/Procedures:_______________________________
☐ Ulcers:_______________________________	☐ Thyroid Disease:_______________________________
☐ Seizures:_______________________________	☐ Jaundice/Cirrhosis:_______________________________
☐ Kidney Disease:_______________________________	☐ Colon Polyps:_______________________________
☐ Prostate Disease:_______________________________	☐ Autoimmune Disorder:_______________________________

Other:____

Other:____

Other:____

Have you ever been treated for cancer before?: ☐ No ☐ Yes, please explain:_______________________________

Have you had any prior Surgeries?: ☐ No ☐ Yes

Reason:____Date:_____/_____/_____ Hospital:__________________

Reason:____Date:_____/_____/_____ Hospital:__________________

Reason:____Date:_____/_____/_____ Hospital:__________________

Present Medications:

Preferred Pharmacy?:____Phone #:___________________________________

Address:____

You may also submit a list of current medications if space given is insufficient:

Name:____Dose:_________________How Often?:_________________

Name:____Dose:_________________How Often?:_________________

Name:____Dose:_________________How Often?:_________________

MEDICAL ASSISTANT COPY

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Patient Medical History and Disclosure (Continued)

Allergies: ☐ **No** ☐ **Yes** (if YES, please list any allergies you may have including medications, shellfish, & type of reaction)

____

____

FEMALE PATIENTS ONLY

Are you pregnant?: ☐ N ☐ Y

Age at first menstrual cycle:__________ Age of last menstrual cycle:__________

Have you ever used estrogen? ☐ N ☐ Y How many years?___________

Have you ever used birth control? ☐ N ☐ Y Type:______________________How long?__________

# of pregnancies:_______________ Age of first pregnancy:____________ # of Children_____________________

Past surgery on Breasts? ☐ N ☐ Y If yes, type of surgery and date:_______________________________________

Hysterectomy? ☐ N ☐ Y If yes, type of surgery and date:____

FAMILY HISTORY OF HEALTH PROBLEMS (please list major health problems your family has experienced)

Mother:____

Father:____

Sisters:____

Brothers:____

SOCIAL HISTORY:

Occupation:____

Marital Status: ☐M ☐S ☐W ☐D # of Children: ☐ Male(s) ages:_______________ ☐ Female(s) ages:_______________

Who do you live with?____

Do you drink alcohol? ☐ N ☐ Y Past use of alcohol? ☐ N ☐ Y Amount:________________ Years of use:_______________

Would you be interested in? ☐ Nutritional Counseling ☐ Psychological Counseling ☐ Social Worker Counseling
☐ Pain Specialist ☐ Acupuncture or Acupressure ☐ Naturopathic Medicine

Smoking Status: ☐ Currently every day smoker ☐ Currently an occasional smoker ☐ Former smoker ☐ Never a smoker
☐ Decline to answer

We welcome you to our medical practice. As a part of the management of your care, your physician (including any owners of the medical practice) may refer you to one or more of the following services: laboratory, imaging, CT, MRI, PET, nuclear medicine, ultrasound, radiation therapy, thermal therapy or other services we provide as part of our medical group. This is to inform you that your physician may have a financial interest in one or more of these services. You may choose any provider for the purpose of obtaining services ordered or requested by our physicians. I acknowledge and understand the foregoing.

Print Name:____

Signature:____

Date:____

MEDICAL ASSISTANT COPY

Patient Medical History and Disclosure (Continued)

Patient Name:____

General:	☐ fevers ☐ chills ☐ drenching sweats ☐ weight gain ☐ weight loss ________lbs over______months
Skin:	☐ color changes ☐ itching ☐ bruising ☐ bleeding ☐ rash ☐ changes in birthmarks/moles
Lymph Nodes:	☐ enlarged ☐ painful **WHERE:** ☐ Neck ☐ Underarms ☐ Groin
Head/Neck	☐ headaches ☐ dizziness ☐ visual changes/ double vision ☐ hearing loss ☐ ear ringing/pain ☐ nosebleeds ☐ mouth sores ☐ dental problems ☐ sore throat ☐ voice changes
Respiratory:	☐ shortness of breath ☐ cough ☐ wheezing ☐ sputum production ☐ coughing up blood
Cardiovascular:	☐ palpitations ☐ irregular heartbeat ☐ chest pain
Gastrointestinal:	☐ nausea/vomiting ☐ difficulty swallowing ☐ abdominal pain ☐ diarrhea ☐ blood in stools ☐ black tarry stools ☐ yellow skin or eyes
Urological	☐ burning with urination ☐ difficulty starting a stream ☐ incontinence ☐ blood in urine
Musculoskeletal:	☐ arthritis ☐ painful/swollen joints ☐ muscle weakness or wasting ☐ back pain ☐ leg swelling
Endocrine:	☐ hot/cold intolerance ☐ appetite change ☐ increased thirst
Neurologic:	☐ focal weakness ☐ numbness/tingling ☐ walking difficulties ☐ coordination problems ☐ seizures
Hematology:	☐ anemia ☐ recent bleeding ☐ blood clots ☐ recurrent infections

	Physician Notes

MEDICAL ASSISTANT COPY

Advanced Directives Questionnaire

Please answer the following questions if you are able to do so. The Nursing staff and/or Medical Assistant will provide assistance if necessary.

Name:____ Date:_______/______/________

1. Do you have a:
   - Durable Power of Attorney for Health Care ☐ Yes ☐ No
   - Executed Living Trust ☐ Yes ☐ No

**** If "Yes" to either of the above it is your responsibility to provide us with a copy for your record within five days.**

2. If "No" would you be interested in more information? ☐ Yes ☐ No

Signature:____ Date:_____________________________________

Witness Print Name:________________________________ Witness signature:___________________________

PATIENT COORDINATOR COPY

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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 AS REQUIRED BY THE PRIVACY REGULATIONS CREATED AS A RESULT OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY

We understand that medical information about you is personal. We are committed to protecting medical information about you. Each time you visit a hospital, physician or other healthcare provider, a record of your visit is made. This notice applies to all of the records of your care that we maintain, whether created by facility staff or your personal physician.

As required by law, we will:

- keep medical information about you private;
- provide, or make available, as applicable, this notice of our legal duties and privacy practices with respect to medical information about you; and follow the terms of the notice that is currently in effect.

Obtain a copy of this notice
You have the right to a current copy of this notice. You may obtain a copy of this notice any time in person or by written request

How we may use and disclose medical information about you
We will share medical information about you for purposes of treatment, such as sending medical information about you to your physician or specialist as part of a referral, to obtain payment for treatment, and to support health care operations.

We may use health information about you without prior authorization for several other reasons. Subject to applicable law to carry out their duties, we may give out medical information about you to other entities for:

- public health authorities that are authorized by law to collect the information (such as, births, deaths, public surveillance)
- abuse, neglect or domestic violence reporting when it is a threat to your safety and the safety of another individual or the public
- health oversight audits or inspections
- research studies
- workers' compensation purposes
- emergencies
- requests from law enforcement, or in response to valid judicial or administrative orders

Your rights regarding medical information about you
You have the right to look at or get a copy of medical information that we use to make decision about your care. We will provide you with a form you can complete to make the request. If you request copies, however, we may charge a fee for copying, mailing and other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for review of that decision.
You have the right to request us to amend your health information if you believe it is incorrect or missing. We will provide you a form which you can complete to make the request. We may deny your request to amend a record if the information was not created by us, if it is not part of medical information maintained by us, or if we determine that the record is accurate. If we deny your request to amend, you may submit a request to review that decision by us not to amend the record.
You have the right to make a written request to us for a list of instances where we have disclosed medical information about you other than for treatment, payment, health care operations or where you specifically authorized disclosure.
You have the right to request that medical information about you be communicated to you in a confidential manner.
You may request, in writing, that we not use or disclose medical information about you for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. We will consider your request but our processes may not be able to accommodate it and we are not legally required to accept it. We will inform your of our decision on your request.

All written requests for review of denials should be submitted to our Privacy Officer

Other uses of medical information
In any other situation not cover by this notice, we will ask for your written authorization before using or disclosing medical information about you. If we request and obtain your authorization to use or disclose your medical information, you can later revoke authorization by notifying us in writing.

Complaints
If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact our Facility Privacy Office in writing. Finally, you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. Under no circumstance will you be penalized or retaliated against for filing a complaint.

If you have any questions regarding this Notice of Privacy Practices please contact us at Beverly Hills Cancer Center, 8900 Wilshire Blvd., Beverly Hills, CA 90211, or call 310-432-8900.

PATIENT COPY

Patient HIPAA Statement

I understand as part of my healthcare, the Beverly Hills Cancer Center originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand this information serves as:

- A basis for planning my care and treatment;
- A means of communication among the many health professionals who contribute to my care;
- A source of information for applying my diagnosis and health information for billing purposes;
- A means by which a third-party payer can verify that services billed were actually provided;
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I acknowledge that I have received, read, and understand Beverly Hills Cancer Center's *Notice of Privacy Practices,* which provides a more complete description of information uses and disclosures. I have the right to review this notice prior to signing this consent. I understand the organization reserves the right to change their notice and practices at any time and I may request a copy of any revised notice by contacting our Privacy Officer at (310) 432-8900.

I understand I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this organization is not required to agree to the restrictions requested.

This acknowledgement is given freely with the understanding that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as authorized by law. A photocopy or fax of this consent is as valid as this original.

______________________________ ______________________________

Print Patient's Name Date

______________________________ ______________________________

Patient's Signature (or personal representative) Date

PATIENT COORDINATOR COPY

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Financial Policies

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care. For your convenience, we have answered a variety of financial policy questions. If you need further information about any of these policies, please ask to speak with a Billing Specialist or call our billing office at 310-432-8959.

We accept payment by cash, check, VISA, Discover, American Express and MasterCard. **We have a secure place in our billing system to store credit card information with access only by the billing department. Once your insurance company has paid its portion we will then put your co-payment, co-insurance and/or deductible on this credit card. This will reduce statements sent to you and not require you to pay your co payment at the time of service.**

Please review the entire policy. Your financial responsibility depends on a variety of factors as explained below.

	YOU ARE FINANCIALLY RESPONSIBLE FOR:	**OUR STAFF MAY ASSIST WITH THE FOLLOWING:**
PPO PLAN **POS (POINT OF SERVICE PLAN)** (CONTRACTED PROVIDER or IN NETWORK)	If the services you receive are covered by the plan**: ALL** applicable co-pays, coinsurance, and deductibles are requested at the time of the service. If the services you receive are **NOT** covered by the plan: Payment in full is requested at the time of the visit.	Call your insurance company ahead of time to determine co-pay, coinsurance, and deductible. File an insurance claim on your behalf.
POS (POINT OF SERVICE PLAN) (OUT OF NETWORK)	Payment of the co-pay, coinsurance, and deductible is due at the time of service. If the services you receive are not covered by out of network coverage: Payment in full is requested at the time of the visit.	Call your insurance company ahead of time to determine co-pay, coinsurance, and deductible. File an insurance claim on your behalf.
MEDICARE	If you have Medicare with no secondary insurance we will ask that your deductible be paid at the time of the visit. Payment of your 20% coinsurance is requested at the time of the visit.	File the claim on your behalf, as well as any claims to your secondary insurance.
MEDI-CAL	We are a Medi-Cal provider	File the claim to Medi-Cal and secure authorization prior to services being rendered.
NO INSURANCE	Payment in full at the time of the service or arrangements to be made prior, during or after treatment or visit. Financial agreements may be required to be signed prior to services being rendered. Patient is responsible for all costs.	Inform you of our Fee Schedule. Arrange for a member of our billing team to speak with you as needed.
HMO PLAN	Authorization and co-payments are required prior to any services being rendered.	New patients – authorizations must be obtained by your PCP prior to your visit. Existing patients-–our staff will secure the authorization prior to services being rendered.
HMO PLAN (WE ARE **NOT** A CONTRACTED PROVIDER)	**Payment in full** for office visits, labs, chemotherapy, injections and all other services.	Inform you of our Fee Schedule.

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Miscellaneous Administrative Costs to Patients:

CLINICAL TRIAL PARTICIPATION	Standard of care – Services performed if you were on a standard regimen: Services would include but not limited to lab tests, central line care, physician visits, radiation therapy and outpatient diagnostic testing will be charged to your insurance company as allowed by California State Law.	Standard of care financial consultation to be discussed prior to treatment by a member of the billing team or at time of consent process by MD, RN and/or billing team.
ACCIDENT / LIEN CASES	All attorney information and a signed lien is required prior to diagnostic testing or any services being performed. Agreement will be signed that **in the event your legal case is not successful, you, as the patient, are responsible for cost of the services rendered.**	Agreement signed by patient and attorney prior to services being rendered.
WORKERS COMPENSATION	All information regarding the work compensation case including WC claim number, date of injury, insurance company name and address, adjustor's name and telephone no, and employer's name and telephone. If work comp case has not been established, case may be handled as a lien case.	File an insurance claim on your behalf.

No Show Cancellation Policy

- **New Patient consultation** – We would appreciate the courtesy of a call if you cannot keep your consultation appointment as there is typically a waiting list of patients to see Beverly Hills Cancer Center physicians and to receive services. Please notify our office at least forty-eight (48) hours prior to the appointment time or you will be charged $50.00 via a credit card received in advance which is included in new patient paperwork, otherwise, you will receive a bill for this charge.

- **Follow up appointments** – We would appreciate the courtesy of a call if you cannot keep an appointment. Please notify our office at least (24) hours prior to the appointment time. We reserve the right to charge you a missed appointment fee of $30.00 and will either automatically charge your credit card on file or send you a bill for this charge.

- **Imaging/Radiology Appointments** – There are supply and other costs for these appointments. Please notify our office at least (24) hours (business hours) prior to the appointment time or you will be charges a cancellation fee. These fees range from $50.00 - $350.00 depending on the service. We will either automatically charge your credit card on file or send you a bill.

Physician Telephone Calls:

Our physicians are unable to assess a patient's medical needs over the phone and may also not have access to a patient's full medical record depending on where they may be calling from. If you need to speak with your doctor, including any discussions regarding results of diagnostic testing, we will provide you with an appointment. For urgent issues, you may need to be seen by another Beverly Hills Cancer Center physician or the nearest emergency room as medically appropriate.

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Returned Check Fee

- You will be charged $25.00 per occurrence when a check does not clear our financial institution.

Special Report/Form Fee

- You will be charged $15.00 per document that is required to be prepared by the physician. This will include, but will not be limited to State Disability forms, DMV forms, airline letters, jury duty letters, etc. An invoice will be issued to you or charged to your credit card on file. Payment will be required in advance of documentation being returned to you.

CD for Imaging Studies

- First CD is free. Additional copies will be charged at $20.00 per CD to be collected at time of request.

Delinquent Accounts Fee:

As you are aware, there have been many changes in insurance coverage for physician services during the last few years. Some of these changes have resulted in significantly decreased reimbursement paid to physicians for services rendered. In our practice, insurance companies have continually delayed payment for treatment, including reimbursement for chemotherapy agents that Beverly Hills Cancer Center has purchased for patient care. This delay and failure to pay in some cases has jeopardized Beverly Hills Cancer Center's ability to care for other patients; therefore, we have instituted the following charges for delinquent or unpaid accounts:

- **A delinquent account service fee of $20.00 per month will be added to a monthly statement beginning 75 days after receipt of a patient's insurance payment or insurance denial.**

- **Credit card authorization will be kept on file and charged for all co-pays, co-insurance, and deductible per a patient's explanation of benefits. Once the explanation of benefits is received in our office, your credit card will be charged only for the indicated co-pay, co-insurance and/or deductible.**

- **Collection Agency – If payment in full is not timely received, we reserve the right to refer your account to a collection agency.**

I, the undersigned, have read, understand, and agree to the above Financial Policy. I agree to promptly pay per the Financial Policy for all of the products received and services rendered to the patient identified below. I understand that all charges not covered by my insurance company or other applicable payor, as well as applicable co-payments and deductibles, are my responsibility and I will promptly pay them. If any payments or charges are due at or prior to the time of service are not made at such time, then they are due immediately thereafter. I, the undersigned, agree to be personally and fully responsible for complete payment to Beverly Hills Cancer Center for all services and products and shall also be responsible for all attorneys' fees and collections costs incurred by Beverly Hills Cancer Center relating to collection.
I authorize my insurance benefits be paid directly to Beverly Hills Cancer Center/Optima Diagnostic Imaging.
I authorize Beverly Hills Cancer Center/Optima Diagnostic Imaging to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim

Printed Name of Patient:____

Signature of Patient (or Representative or Responsible Party): ____

Printed Name of Person Signing: ____Date: _______________________

NOTE: Please return the enclosed credit card authorization form along with this signed letter if you choose to have us charge your credit card automatically as described above so you will not be charged co-pays on day of service and receive no statements for those amounts.

PATIENT COORDINATOR COPY AND PATIENT COPY (Page 3 of 3)