VIDA FAMILY PRACTICE, PC.

PATIENT INFORMATION

Name (Last, First, Middle) _____ Social Security # _____

Sex ☐M ☐F Age_____ Birth Date _____ ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Race_____Ethnicity_____Religion_____

Address _____City _____ State _____ Zip _____

Home Phone _____ Mobile/Work Phone _____ Preferred ☐Home ☐Mobile/Work

Email _____ How did you hear about us?_____

Patient Employed By _____ Supervisor _____

Primary Care Physician _____ Phone _____

In case of Emergency (Name, Phone, Relation) _____

PARENT/GUARANTOR INFORMATION

Name (Last, First, Middle) _____

Social Security # _____ Age_____ Birth Date _____ Sex ☐M ☐F

Address _____City _____ State _____ Zip _____

Home Phone _____ Mobile/Work Phone _____ Preferred ☐Home ☐Mobile/Work

Email _____ Relationship to Patient ☐Parent ☐Guardian ☐Spouse ☐Employer

PRIMARY INSURANCE

Carrier _____

Subscriber ID _____ Group # _____

Insurance Claims Address _____

Phone _____

Policy Holder Name _____

Social Security # _____ Sex ☐M ☐F

Birth Date _____

Relationship to Patient ☐Parent ☐Guardian ☐Spouse

SECONDARY INSURANCE

Carrier _____

Subscriber ID _____ Group # _____

Insurance Claims Address _____

Phone _____

Policy Holder Name _____

Social Security # _____ Sex ☐M ☐F

Birth Date _____

Relationship to Patient ☐Parent ☐Guardian ☐Spouse

AUTHORIZATION AND RELEASE

Authorization of Treatment: I voluntary consent to the administration and cost of medical and surgical procedures, x-ray and medication for myself and my dependents

Assignment of Insurance Benefits: I authorized payment directly to VIDA Family Practice, PC for all benefits otherwise payable to me.

Guarantee of Payment: I understand that I am financially responsible and agree to pay all of the charges that are not paid or billed to insurance or any other third party payer. I understand that I must pay in full today for all services rendered unless my insurance is accepted. I also understand that if my insurance is accepted, I must pay all applicable insurance copays, coinsurances and deductibles today. If you are unable to verify my insurance at time of service, I will pay in full for all services.

Release of Records: I authorize VIDA Familly Practice, PC to release (verbal or in writing) confidential medical information to any person or entity including my insurance carrier, employer if treatment is related to employment purposes, or other health care operation which may be liable to me or my practitioner(s) for charges for this treatment and for quality management, utilization review, transfer and follow-up purposes.

Receipt of Privacy Practices: I acknowledge that a copy of the Notice of Privacy Practices of VIDA Family Practice, PC is available to me upon request and can be provided at the office and on the website. I understand that a copy of this agreement may be used with the same effectiveness as the original.

Patient Signature _____ Date _____

Responsible Party _____ Date _____

VIDA FAMILY PRACTICE, PC

Patient's Name:_____ **Age:**_____

BP:_____ Pulse:_____ RR:_____ Wt:_____ HT:_____ O2Sat:_____ Temp:_____

Past Medical History

- ☐ Alcoholism
- ☐ Allergies / Hives
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Aids / HIV
- ☐ Back Pain
- ☐ Blood Disease
- ☐ Blood Transfusions
- ☐ Cancer
- ☐ Diabetes
- ☐ Depression
- ☐ Eating Disorders
- ☐ Epilepsy/Seizures
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ Heart Valve Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Joint Disorders
- ☐ Kidney Disorder
- ☐ Liver Disorder
- ☐ Lung Disorder
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ STD
- ☐ Skin Disorders
- ☐ Stroke
- ☐ Stomach Disease
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Chronic Pain Syndrome
- ☐ Chronic Pain Medication use

If Chronic Pain present, Complete Pain Assessment Form

Surgeries & Hospitalizations

_____ Date_____
_____ Date_____
_____ Date_____

Preventive Care

Last Colonoscopy:_____
Last Mammogram:_____
Last Pap Smear:_____
Age menses started:_____

Family History:

Father _____ Siblings_____
Mother _____ Children_____
Grandparents:_____ Other _____

Social History

Alcohol use: ☐ Never: ☐ Occasional: ☐ 1-2 Drinks/day: ☐ >2 Drinks/day # Drinks/wk_____
Tobacco use: ☐ Never: ☐ Former smoker, year quit:_____ Current packs/day:_____
Drugs use: ☐ Never: ☐ Former user, year quit_____ Drug Type/years_____

Medications (include non-prescription)

_____
_____

Allergies:_____

Immunizations

Last PPD date:_____ New PPD offered:_____ Tdap_____
Pneumonia vaccine:_____ Influenza Vaccine:_____ Other:_____

Physician's Signature _____ Date _____

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** 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 a 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 rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service 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. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure Section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services _____

Patient's or Patient Representative's Initials

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.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

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.

By: _____ _____

Physician's or Authorized Representative's Signature Date

VIDA FAMILY PRACTICE PC, Dr. Vigen V. Abovian, MD
435 Arden Ave. Ste 330, Glendale CA 91203
Tel. 818-548-8001 Fax. 877-548-0506

Print or Stamp Name of Physician, Medical Group, or Association Name

By: _____ _____

Patient's or Patient Representative's Signature Date

By: _____

Print Patient's Name

_____

(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.

VIDA FAMILY PRACTICE, PC. Payment Policy

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Noncovered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in **[45 days]**, the balance will automatically be billed to you.

7. Nonpayment. If your account is over **[90 days]** past due, you will receive a letter stating that you have **[20 days]** to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have **[30 days]** to find alternative medical care. During that **[30-day]** period, our physician will only be able to treat you on an emergency basis.

8. Minor Patients. Written or verbal parental consent is required by law, if a minor is not accompanied by a parent. For families with dual insurance coverage, a birthday law applies. The birthday (birth month) of the parent that falls first is the year becomes primary

9. Missed Appointments: Due to our efforts to accommodate all patients when they need to be seen, we ask that if you are not able to keep your scheduled appointment, that you cancel no later than 24 hours in advance. We understand that although circumstances at times may prevent your doing this, after a second missed appointment we may add a $10.00 missed appointment charge to your account.

10. Other Fees. In the event that you need copies of your medical records transferred to another primary care physician a copy fee will be charged. Third party physical exams that requires additional forms to be completed by physicians or staff may be subject to a **$50.00 - $100.00 forms** fee. Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

I have read and understand the payment policy and agree to abide by its guidelines:

Print Name of patient or responsible party	**Relationship**
Signature of patient or responsible party	**Date**

VIDA FAMILY PRACTICE, PC.

Notice of Privacy Practices
Effective Date: August 10, 2017

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Your medical record may contain personal information about your health. This information may identify you and relate to your past, present or future physical or mental health condition and related health care services and is called Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

How we may use and disclose health care information about you:

For Care or Treatment: Your PHI may be used and disclosed to those who are involved in your care for the purpose of providing, coordinating, or managing your services. This includes consultation with clinical supervisors or other team members. Your authorization is required to disclose PHI to any other care provider not currently involved in your care. ***Example:*** *If another physician referred you to us, we may contact that physician to discuss your care. Likewise, if we refer you to another physician, we may contact that physician to discuss your care or they may contact us.*

For Payment: Your PHI may be used and disclosed to any parties that are involved in payment for care or treatment. If you pay for your care or treatment completely out of pocket with no use of any insurance, you may restrict the disclosure of your PHI for payment. ***Example:*** *Your payer may require copies of your PHI during the course of a medical record request, chart audit or review.*

For Business Operations: We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. We may also disclose PHI in the course of providing you with appointment reminders or leaving messages on your phone or at your home about questions you asked or test results. ***Example:*** *We may share your PHI with third parties that perform various business activities (e.g., Council on Accreditation or other regulatory or licensing bodies) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI.*

Required by Law: Under the law, we must make disclosures of your PHI available to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule, if so required.

Without Authorization: Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. Examples of some of the types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission: We may use or disclose your information to family members that are directly involved in your receipt of services with your verbal permission.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked. Your explicit authorization is required to release psychotherapy notes and PHI for the purposes of marketing, subsidized treatment communication and for the sale of such information.

Your rights regarding your PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer:

- **Right of Access to Inspect and Copy**. You have the right, which may be restricted only in exceptional circumstances or with documents released to us, to inspect and copy PHI that may be used to make decisions about service provided.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures**. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the use or disclosure of your PHI for services, payment, or business operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about PHI matters in a specific manner (e.g. telephone, email, postal mail, etc.)
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

Website Privacy

Any personal information you provide us with via our website, including your e-mail address, will never be sold or rented to any third party without your express permission. If you provide us with any personal or contact information in order to receive anything from us, we may collect and store that personal data. We do not automatically collect your personal e-mail address simply because you visit our site. In some instances, we may partner with a third party to provide services such as newsletters, surveys to improve our services, health or company updates, and in such case, we may need to provide your contact information to said third parties. This information, however, will only be provided to these third-party partners specifically for these communications, and the third party will not use your information for any other reason. While we may track the volume of visitors on specific pages of our website and download information from specific pages, these numbers are only used in aggregate and without any personal information. This demographic information may be shared with our partners, but it is not linked to any personal information that can identify you or any visitor to our site.

Our site may contain links to other outside websites. We cannot take responsibility for the privacy policies or practices of these sites and we encourage you to check the privacy practices of all internet sites you visit. While we make every effort to ensure that all the information provided on our website is correct and accurate, we make no warranty, express or implied, as to the accuracy, completeness or timeliness, of the information available on our site. We are not liable to anyone for any loss, claim or damages caused in whole or in part, by any of the information provided on our site. By using our website, you consent to the collection and use of personal information as detailed herein. Any changes to this Privacy Policy will be made public on this site so you will know what information we collect and how we use it.

Breaches:

You will be notified immediately if we receive information that there has been a breach involving your PHI.

Complaints:

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our **Privacy Officer at *VIDA FAMILY PRACTICE PC.*** If you have questions and would like additional information, you may contact us at 818-548-8001.

“HIPAA” PATIENT ACKNOWLEDGMENT FORM

I understand that under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such **Notice of Privacy Practicies** prior to signing this consent. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this organization at any time at the address bellow to obtain a current copy of the **Notice of Private Practices**.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this acknowledgement in writing at any time except to the extend that you have taken action relying on ths acknowledgement.

Patient Name: _____

Authorized Representitive: _____

Signature: _____

Date: _____

VIDA FAMILY PRACTIC PC.

“OPEN PAYMENTS SEARCH”

ACKNOWLEDGMENT FORM

The open payment database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found on:

https://opnepaymentsdata.cms.gov

Patient Name:_____

Signature:_____

Date:_____

VIDA FAMILY PRACTICE PC.

ADVANCE HEALTH CARE DIRECTIVE
(California Probate Code Section 4701)

Dear Patient:

As you Physician we are required to ask any patient over the age 18 if they have an existing Advanced Health Care Directive so that we can incorporate the information into your medical records. You are not required to give us this information, but we are required to ask. Please complete this form and return it to the receptionist.

Thank you.

PATIENT NAME:_____ DOB:_____

I decline to answer these question ☐ Yes ☐ No

Do you have an Advance Health Directive? ☐ Yes ☐ No

If yes, please indicate which type of Directive:

- ☐ Durable Power of Attorney for Healthcare
- ☐ California Natural Death Act
- ☐ Living Health Care Will
- ☐ Five wishes
- ☐ POLST:
- ☐ Other:_____

Will you bring us a copy of your Directive? ☐ **Yes** ☐ **No**

PATIENT SIGNATURE:_____ DATE:_____

VIDA FAMILY PRACTICE PC

VIDA FAMILY PRACTICE, PC.

PATIENTS' RIGHTS AND RESPONSIBILITES / CONSENT TO TREATMENT

VIDA Family Practice, PC., is dedicated to providing you with the best in health care. Along with technical expertise, we want to provide you a considerate and respectful care with positive patient experience. We respect your rights as a patient and want you to understand your responsibility as a partner in your care.

CONSENT TO TREATMENT

☒ I voluntarily authorize the rendering of such care, including diagnostic procedures and medical treatment, by authorized agents and employees of the VIDA Family Practice, PC., its medical staff and their designees, as may in their professional judgment be deemed necessary or beneficial. I acknowledge that no guarantees have been made as to the effect of such examination or treatment on my condition or the condition of the person for whom I am duly authorized to sign. I understand that I have the right to make decisions concerning my health care or the health care of the person for whom I am duly authorized to make such decisions, including the right to refuse medical and surgical procedures.

This consent to treatment may be revoked in writing at any time by the patient or duly authorized agent.

PATIENTS' RIGHTS

- You have the right to participate in the development and implementation of your plan of care.
- You will not be denied access to care due to race, creed, color, national origin, sex, age, sexual orientation, disability.
- You have the right to information about your diagnosis, condition and treatment, in terms that you can understand.
- You have the right to refuse treatment to the extent permitted by law and to be informed of the possible consequences.
- You have the right to make or have a representative of your choice make informed decisions about your care.
- You have the right to formulate advance directives and have them followed.
- You have the right to appropriate assessment and management of pain.
- You are entitled to information about rules and regulations affecting your care or conduct.
- You have the right to know the names and professional titles of your physicians and caregivers.
- You have the right to personal privacy and to receive care in a safe environment.
- You have the right to a prompt and reasonable response to any request for services within the capacity of our clinic
- You have the right to express concerns or grievances regarding your care to the office.
- The confidentiality of your clinical and personal records will be maintained.
- You have the right to see your medical record within the limits of the law.
- You have the right to an explanation of all items on your bill.

PATIENTS' RESPONSIBILITES

- It is your responsibility to provide accurate and complete information about all matters pertaining to your health
- You are responsible for following the instructions and advice of your health care team.
- If you refuse treatment or do not follow the instructions or advice, you must accept the consequences of your actions.
- It is your responsibility to notify us if you do not understand information about your care and treatment.
- You are responsible for reporting changes in your condition or symptoms, to a member of the healthcare team.
- It is your responsibility to act in a considerate and cooperative manner and to respect the rights and property of others.
- You are responsible for following the rules and regulations of the health care facility.
- You are expected to keep your scheduled appointments or to cancel them in advance if at all possible.
- It is your responsibility to pay your bills or make some arrangement with the facility to meet your financial obligations.

I certify that I have read and understood the authorization to treatment given above, as well as the patients' rights and responsibilities specified in this agreement, and I accept its terms.

_____ _____

Date Signature of Patient or Designee and Relationship to Patient

VIDA FAMILY PRACTICE PC.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

The undersigned hereby authorizes **VIDA Family Practice, PC.,** to use or disclose copies of certain medical record information as specified below:

PATIENT NAME _____ BIRTH DATE:_____

MED REC#_____ ID#:_____PHONE:_____

ADDRESS: _____

INFORMATION AUTHORIZED FOR USE OR DISCLOSURE: ☐ **ENTIRE MEDICAL RECORD**

☐ History AND Physical ☐ Discharge Summary ☐ Operative Reports ☐ LAB Reports
☐ Pathalogy Reports ☐ Progress Notes ☐ Orders ☐ X-RAY Resluts

I UNDERSTAND:

- I may revoke this authorization at any time, in writing, except revocation will not apply to information already obtained, used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Practices.
- I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the Privacy Rule.

This Authorization will remain in effect:

☐ From the date of this Authorization until:_____
☐ Until the following event occurs:_____

Unless otherwise noted above this authorization will remain in effect 180 days from this date

THE INFORMATION AUTHORIZED FOR USE OR DISCLOSURE MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT IS NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA OR THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).

NOTICE TO RECIPIENT OF COPIES OF ALCOHOL AND DRUG ABUSE MEDICAL RECORDS:

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Chap. 1, Part 2, Subpart Cə § 2.32). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Chap. 1, Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Federal regulations state that any person who violates any provision of this law shall be fined not more than $500 for the first offense and $5,000 in the case of a subsequent offense.

THIS DOCUMENT SPECIFICALLY AUTHORIZES THE RELEASE OF PSYCHIATRIC INFORMATION. IF PSYCHIATRIC INFORMATION IS INCLUDED IN THE INFORMATION TO BE RELEASED TO THE PATIENT, PHYSICIAN CONSENT FOR SUCH RELEASE MUST BE OBTAINED

With this knowledge, I give my authorization to the release of all information in my medical records, including any information concerning my identity, and release **VIDA Family Practice, PC**, its affiliates, agents and employees, from any liability in connection with the release of the information contained therein.

_____ _____

PATIENT SIGNATURE / LEGAL REPRESENTATIVE **DATE**

VIDA FAMILY PRACTICE, PC.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I hereby give my consent for VIDA FAMILY PRACTICE, PC. to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by VIDA Family Practice, PC., describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. VIDA Family Practice, PC., reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to privacy officer: Vigen Vick Abovian, MD. By signing this form, I am consenting to allow VIDA Family Practice, PC. to use and disclose my PHI to carry out TPO.

With this consent, VIDA Family Practice, PC., may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, and any calls pertaining to my clinical care, including laboratory test results, among others, and may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential." I may revoke 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, VIDA Family Practice, PC., may decline to provide treatment to me.

PATIENT RECORD OF DISCLOSURES

I wish to be contacted in the following way:

□ **Home Telephone** _____
- □ O.K. to leave message with detailed information
- □ Leave message with call-back number only.

□ **Written Communication**
- □ O.K. to mail to my home address
- □ O.K. to mail to my work/office address
- □ O.K. to fax to this number _____

□ **Work Telephone** _____
- □ O.K. to leave message with detailed information
- □ Leave message with call-back number only

____ **I AGREE NOT TO USE ANY EMAIL OR TEXTING COMMUNICTIONS FOR MY MEDICAL RECORDS OR HEALTHCARE QUESTIONS.**

_____ Print Patient's name

_____ Signature of Patient or Legal Guardian

_____ Print Name of Patient or Legal Guardian

_____ Date

VIDA FAMILY PRACTICE, PC.

Authorization to Release Personal Health Information (PHI) to Insurance Carrier

I hereby authorize payment directly to **VIDA Family Practice, PC.,** and authorize the practice to release all information necessary to obtain payment for services provided. This authorization applies to all insurance companies and/or their intermediaries (either directly or through a third party billing company), including Medicare, Medicaid, private health insurer, HMO, or other company or program that is designated to pay for my health care. I understand that this information might be released for making a determination of eligibility or coverage for insurance benefits, reviewing services provided to determine medical necessity if required by my insurance company, and undertaking utilization review or case management activities with respect to claims.

I understand I am responsible for fees not paid in full, co-payments, and policy deductibles except where my liability is limited by contract or State or Federal law. I understand that filing a claim for payment with my insurance company, or other party, does not relieve me from the responsibility of payment for charges for services delivered to me or my dependents.

I agree that that this authorization shall remain in effect until the authorization is revoked.

Signature of Patient or Guardian: _____

Date (mm/dd/yy): ___ /___ /____

Printed Name of Patient or Guardian_____

Witness:_____

VIDA FAMILY PRACTIC, PC.

NON-COVERED
FORM / PAPERWORK COMPLETION FEES AND POLICIES

January, 2017

TO OUR PATIENTS:

Effective January, 2017 our practice has adapted a policy to charge **Administrative Fees** to our patients for **Non-Covered Paperwork/Forms** services that are requested to be provided by the physician outside medical office visit time.

The fees will range for $50 - $150 per document depending on complexity and number of pages, to a maximum of $300 per year. **Separate Additional Fees** will be charged for **Citizenship Disability Form AND Medical Disability Reports.**

Alternatively, one time annual administrative fee of $300 per year can be paid, for all non-covered paperwork services provided by physician outside the medical office visit time. **Separate Additional Fees** will be charged for **Citizenship Disability Form AND Medical Disability Reports.**

Payment should be done before completing the form (when the form is dropped off or mailed in), OR before releasing the form to the patient.

WE WILL CHARGE FOR THE FOLLOWING SERICES:

- **School forms**
- **Camp forms**
- **Sports participation forms**
- **Disability forms**
- **FMLA forms**
- **Life insurance forms**
- **Paperwork for patient assistance programs**
- **ADHC OR CBAS attendance certifications**
- **Copies of medical records**
- **No-shows**
- **DMV Forms**
- **Health Certification/ Clearance for employment**

PATIENT ACKNOWLEDGMENT

I have read and understand the above non-covered paperwork policy, that I will be responsible for all non-covered paperwork fees, and if the fees are not paid the office has no obligation to prepare these forms.

_____ _____
(Print Name) Relationship to Patient

_____ _____
Patient / Parent / Guardian Signature Date Signed

_____ _____
Witness: Print Name/sign Date Signed

435 Arden Ave. Suite # 330, Glendale, CA. 91203
Tel. (818) 548-8001, Fax. (877) 548-0506

Consent to Use Telemedicine

Patient's Name_____ My Doctor's Name Vigen Vick Abovian, MD

CONSENT TO USE TELEMEDICINE

I am physically located in California. At the beginning of each telemedicine session, I will help my doctor to complete a check-in to assess the suitability of using telemedicine services by verifying my full name, my current location, my readiness to proceed, and whether I am in a situation conducive to private, uninterrupted communication. By signing this consent, I understand and agree:

1. My doctor is located in and licensed by the State of California. My doctor may not be able to prescribe medications for me and/or may not be able to assist me in an emergency situation when I am located in any other state or country. If I require medication, I may contact my doctor. If I require emergency care, I may call 911 or proceed to the nearest hospital emergency room for help.

2. I submit to the exclusive jurisdiction of the California state superior courts and agree that any claim, lawsuit, or other legal proceeding arising out of or relating to the telemedicine services provided by my doctor and my doctor's staff will be brought solely and exclusively in California state superior courts. I also agree that the interpretation of this consent will be exclusively governed by and construed in accordance with the laws of California.

3. My doctor believes that telemedicine services are appropriate for my medical condition and that I would benefit from its use despite its risks and limitations. While I may expect anticipated benefits from the use of telemedicine, no specific results can be guaranteed or assured.

4. If my doctor believes at any time that another form of services (for example, a traditional in-person consultation) would be appropriate, my doctor may discontinue telemedicine services and schedule an in-person consultation with my doctor or refer me to a healthcare provider in my area who can provide such services.

5. I have the right to withdraw consent to the use of telemedicine services at any time and receive inperson healthcare services with my doctor.

6. I received an explanation of how the electronic communications technology will be used for the telemedicine services. I am comfortable with using electronic communications technology to communicate with my doctor and understand there are limitations to the technology which may require an in-person consultation.

7. I agree to have the necessary computer, equipment and internet access for my telemedicine communications. I also agree to arrange for a location with sufficient lighting and privacy and is free from distractions and intrusions during my telemedicine communications.

8. The laws that protect privacy and the confidentiality of my medical information also apply to telemedicine. The medical information that is transmitted electronically by my doctor to me will be encrypted during transmission and will be stored only by my doctor or a service provider selected by my doctor. I understand the dissemination of any personally-identifiable images or information from the telemedicine communication to researchers or other healthcare providers will not occur except as required by federal or California state law.

9. I understand my risks of a privacy violation increase substantially when I enter information on a public access computer, use a computer that is on a shared network, allow a computer to "autoremember" usernames and passwords, or use my work computer for personal communications. I also understand it is my responsibility to encrypt medical information I transmit electronically to my doctor and my failure to use technical safeguards, such as encryption, increases my risks of a privacy violation.

10. [I agree to be videotaped and recorded during the telemedicine services. I understand the resulting images and audio will become part of my medical record.] OR [No part of the encounter will be recorded without my written consent.]

11. I have the right to access my medical information and obtain copies of my medical records in accordance with California law.

12. I understand that the telemedicine services provided to me will be billed to my health insurance company and that I will be billed for any patient responsibility as per my insurance.

I read and understand the information provided in this Consent to Use of Telemedicine. I discussed any questions I had with my doctor and all of my questions were answered to my satisfaction.

_____ _____

Date Patient's Signature

About Telemedicine

WHAT IS TELEMEDICINE?

Telemedicine (also sometimes called telehealth) services are a way to deliver healthcare services locally to a patient when the healthcare provider is located at a distant site. Telemedicine is generally defined as the use of electronic information and communications technology to exchange medical information from one site to another site to provide medical or surgical treatment to a patient and/or to participate in the medical diagnosis of, or medical opinion or medical advice to, a patient.

When a healthcare provider believes a patient may benefit from the use of telemedicine services, telemedicine can maintain a continuity of care with the provider and facilitate patient self-management and caregiver support of the patient. Telemedicine services often provides a broader access to medical care, eliminates transportation concerns, and increases comfort and familiarity for patients and their families when located in their own homes or other local environments.

However, telemedicine uses new communications technology for which there is little research supporting its effectiveness. For example, telemedicine services may not be as complete as in-person healthcare services because the healthcare provider will not always be able to observe subtle non-verbal communications such as a patient's posture, facial expression, gestures, and tone of voice.

Telemedicine may transfer medical information through the use of interactive, real-time audio/visual technology (for example, video conferencing) or electronic data interchange (for example, computer-to-computer exchanges), or it may transfer medical information through the use of store-and-forward technology (for example, emails). While precautions are taken to secure the confidentiality of telemedicine services, the electronic transmission of medical information can be incomplete, lost or otherwise disrupted by technical failures. Additionally, despite such measures, the transmission and storage of medical information can be accessed by unauthorized persons, causing a breach of the patient's privacy.

I read and understand the information provided in this document. I discussed any question I had with my doctor and all of my questions were answered to my satisfaction.

_____ _____

Date Patient's Signature

Patient Ally

Patient Ally is a personalized and **secure** online access to your medical records. It enables you to securely **manage** and **receive** information about your health. Patient Ally is a FREE service Offered to our patients!

With Patient Ally, you can:

- Request and/or schedule medical appointments
- View your health summary
- View test results
- Communicate securely with your medical care team.

Activate you Patient Ally today, with your email:

_____

VIDA FAMILY PRACTICE PC

VIDA FAMILY PRACTICE PC					
URGENT CARES: affiliated to your medical group	**IPA Medical Group name**				
Locations	**Citrus Valley**	**Maverick Accountable**	**Health Care Partners**	**Regal Lakeside**	**Preferred**
Urgent 9, Urgent Care center 1000 N Central Ave Ste 140, Glendale, CA 91202, **(818) 662-7000** Hours: Mon-Sun, 8am-8pm				X	
Glenoaks Ugent Care 1100 W Glenoaks Blvd. Glendale, CA 91202, **(818) 242-3333** Hours:Mon-Fri 9AM-8PM, Sat/Sun: 9am-5pm	X	X			X
Rapid Care Glendale 801 S Chevy Chase Dr. Ste 105, Glendale, CA, **(818) 265-2200** Hours: M-F 5PM- 8PM Sat/Sun: 9am-5pm				X	X
Verdugo Hills Urgent Care 544 N Glendale Ave # A, Glendale, CA 91206, **(818) 241-4331** Hours: M-F 7am- 8:30pm Weekends &Holiday: 9am - 5:30pm		X	X	X	X
Rapid Care Burbank 1130 W Olive Ave. Burbank, CA. **(818) 843-8555** Hours: M-F 5am-8pm, Sat:9am-5pm				X	X
Health Care Partners, LA 929 Georgia St, Los Angeles, CA 90015, **(213) 861-5950** Hours: Open 24 hours			X		
Lakeside Comm. Urgent care 191 S Buena Vista St # 200, Burbank, CA 91505, **(818) 295-5920** Hours: Mon - Sun: 11am-10pm			X		
Urgent Care-Montrose 1975 Verdugo Blvd, LaCanada/ Flintridge, CA 91011 **(818)249-9454** Hours: M-F 8am-8pm Sat/Sun & Holidays: 9am-5pm			X		
Fair Oaks Urgent Care Pasadena 797 S. Fair Oaks Av. Pasadena, CA 91105 **(626) 795-2244** Hours: Open 24 hours			X		