CONCIERGE MEDICINE LA

Medical history questionnaire • Confidential information

PATIENT INFORMATION

Name _____ (Last) _____ (First) _____ (Middle)

Today's Date _____ Birthdate _____ Age _____ ❑ Male ❑ Female

Home Phone (_____) _____ Cell Phone (_____) _____ E-mail _____

Address _____

City _____ State _____ Zip _____

Social Security # _____ Driver's License # _____ State _____

Employer _____ Business Phone (_____) _____

Address _____

City _____ State _____ Zip _____

Occupation _____

Marital Status ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Ethnicity ❑ Caucasian ❑ African American ❑ Asian ❑ Hispanic ❑ Middle Eastern ❑ Other _____

How did you learn about Concierge Medicine/LA? _____

In Emergency - Contact Name _____ Phone (_____) _____

SPOUSE OR RESPONSIBLE PARTY INFORMATION

Spouse/Responsible Party _____

Home Phone (_____) _____ E-mail _____

Address _____

City _____ State _____ Zip _____

Social Security # _____ Driver's License # _____ State _____

Cell Phone (_____) _____ Business Phone (_____) _____ Birthdate _____

INSURANCE INFORMATION

Do you have medical insurance? ❑ Yes ❑ No. If yes, please provide us with your card for a photocopy to be made.

Relationship to the insured: ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Insured's Name _____

Primary Insurance _____ Group # _____ Policy# Insurance Holder _____

Secondary Insurance _____ Group # _____ Policy# Insurance Holder _____

RELEASE ASSIGNMENT

I hereby authorize Concierge Medicine/LA or designee to disclose when requested by the above named / attached medical insurance carrier or its representative or any other insurance entity any and all information with respect to any illness, injury, medical history, or treatment and copies of all medical records. A Photo Static copy of this authorization shall be as effective and valid as the original.

Signed _____ Date _____

I hereby authorize payments and/or any medical benefits to Concierge Medicine/LA or designee for professional services rendered to me. I understand that I am financially responsible for charges not coved by this authorization. A photo static copy of this authorization shall be considered and effective as the original, although I have requested the physician to bill my medical insurance carrier on my behalf as a courtesy to me, I clearly understand that it is my responsibility to make sure that the bill is paid in a reasonable time. If for any reasons any portion of my bill is not paid by my insurance, I further agree to make arrangements for prompt payment of the bill.

Signed _____ Date _____

Name:_____ Date: _____

MEDICAL INFORMATION

Reason for visit_____

_____

PAST & PRESENT MEDICAL HISTORY: Please list all current medical problems (ie. High Blood Pressure, Diabetes, etc...)

Medical Problem	Year Diagnosed

PAST SURGICAL HISTORY

Surgery	Date

MEDICATIONS

Medication name	Dose	How often

ALLERGIES

	YES	NO
Are you sensitive/allergic to any medications?	❑	❑

If yes, please list: _____

If yes, what happens? _____

FAMILY HISTORY

	Living?	Age/Age of Death	Medical Problems/Cause of Death
Mother	❑ Yes ❑ No	_____	_____
Father	❑ Yes ❑ No	_____	_____
Brother(s)	❑ Yes ❑ No	_____	_____
Sister(s)	❑ Yes ❑ No	_____	_____
Children	❑ Yes ❑ No	_____	_____

Do you have a family history (parents, siblings, children) of:

	YES	NO
Heart attack	❑	❑
Cancer	❑	❑
Diabetes	❑	❑
Stroke	❑	❑

If yes, which family member_____

SOCIAL HISTORY

Do you drink alcohol? ❑ YES ❑ NO

If yes, how often?_____

Have you ever smoked? ❑ YES ❑ NO

Do you smoke now? ❑ YES ❑ NO

If yes, how many packs per day? _____

Have you ever used recreational drugs? ❑ YES ❑ NO (Leave blank

Do you use recreational drugs now? ❑ YES ❑ NO if desired)

If yes, how often?_____

If yes, what type of drugs?_____

FEMALE HISTORY

Number of pregnancies you have had: _____

Number of abortions/miscarriages you have had: _____

Number of children you have: _____

Ages of your children: _____

Age at first menstruation: _____

How many days apart are your periods?_____

How long do your periods last?_____

Are you currently taking birth control pills? _____

Age at menopause: _____

PREVENTIVE MEDICINE: When was your last:

Colonoscopy_____

Mammogram_____

Pap smear _____

Breast exam _____

Prostate exam/PSA _____

Self testicular exam _____

Flu shot _____

Pneumonia vaccine _____

Cardiac stress test_____

MISCELLANEOUS

Birthplace: _____

How long you have lived in this area: _____

Have you ever had a job/hobby involving plastics, chemicals, sandblasting or industrial dusts? ❑ YES ❑ NO

If yes, please describe: _____

Have you traveled to any second or third world countries in the last 2 years? ❑ YES ❑ NO

Would you like to be tested for sexually transmitted diseases? ❑ YES ❑ NO

Name: _____ Date: _____

MEDICAL INFORMATION (continued)

REVIEW OF SYSTEMS

Please check all that apply to you currently:

	YES	NO
GENERAL		
Fever	❑	❑
Chills	❑	❑
Nausea	❑	❑
Vomiting	❑	❑
Unexplained weight loss	❑	❑
SKIN		
Rashes	❑	❑
Lumps	❑	❑
Color change	❑	❑
Dry skin	❑	❑
Hair loss	❑	❑
Irregular moles	❑	❑
HEAD		
Headaches	❑	❑
Dizziness	❑	❑
EYES		
Blurry vision / Double vision	❑	❑
Eye pain	❑	❑
EARS		
Difficulty hearing	❑	❑
Ear ringing	❑	❑
Ear pain	❑	❑
NOSE		
Runny nose / Stuffy nose	❑	❑
Nose bleeding	❑	❑
THROAT		
Sore throat	❑	❑
Difficulty swallowing	❑	❑
BREASTS		
Breast lumps	❑	❑
Breast tenderness	❑	❑
Nipple discharge	❑	❑
LUNGS		
Shortness of breath	❑	❑
Wheezing	❑	❑
Cough	❑	❑
Sputum production	❑	❑
What color _____		
Tuberculosis	❑	❑
Night sweats	❑	❑
Asthma	❑	❑
Emphysema	❑	❑
CARDIOVASCULAR		
Chest pain	❑	❑
Palpitations	❑	❑
Heart murmur	❑	❑
Heart attack	❑	❑
Chest pain with walking	❑	❑
Shortness of breath with lying down	❑	❑
Shortness of breath with exercise	❑	❑
Leg swelling	❑	❑
GASTROINTESTINAL		
Abdominal pain	❑	❑
Heartburn	❑	❑
Diarrhea	❑	❑
Constipation	❑	❑
Abnormal stool	❑	❑
Blood in stool	❑	❑
Hepatitis	❑	❑
Yellow skin	❑	❑
Hemmorrhoids	❑	❑
URINARY		
Burning with urination	❑	❑
Increased frquency of urination	❑	❑
Urinary incontinence	❑	❑
Blood in Urine	❑	❑
Loss of urine with cough/laugh	❑	❑
Kidney stone	❑	❑
Urination at night	❑	❑
How many times per night? _____		
MALE REPRODUCTIVE		
Erectile dysfunction	❑	❑
Decreased libido	❑	❑
Genital sores	❑	❑
Testicular pain	❑	❑
Testicular lumps	❑	❑
FEMALE REPRODUCTIVE		
Genital sores	❑	❑
Vaginal itching	❑	❑
Vaginal discharge	❑	❑
Vaginal pain	❑	❑
Vaginal bleeding	❑	❑
Excessive body/facial hair	❑	❑
Breastfeeding	❑	❑
Pregnant	❑	❑
RHEUMATOLOGIC		
Joint pain	❑	❑
Joint stiffness	❑	❑
Weakness	❑	❑
Dry mouth	❑	❑
METABOLIC		
Excessive hunger	❑	❑
Excessive thirst	❑	❑
Excessive heat intolerance	❑	❑
Excessive cold intolerance	❑	❑
Tremor	❑	❑
Change in skin pigmentation	❑	❑
HEMATOLOGIC		
Bleeding problems	❑	❑
Easy bruising	❑	❑
Transfusion reactions	❑	❑
NEUROLOGIC		
Convulsions	❑	❑
Paralysis	❑	❑
Involuntary movements	❑	❑
Numbness	❑	❑
Epilepsy	❑	❑
Memory dificulty	❑	❑
Speech dificulty	❑	❑
Anxiety	❑	❑
Depression	❑	❑

Is there anything not listed on this form that you would like to tell us?

_____

_____

CONCIERGE MEDICINE LA

Notice of Privacy Practices

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

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

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

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials, if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records, but not including psychotherapy notes. You must submit your request in writing to Raphael Darvish, M.D 11611 San Vicente Blvd., Los Angeles, CA, 90049 or contact number 310 826 2555.
4. You may ask us to amend your health information if you believe it is correct or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Raphael Darvish, M.D. 11611 San Vicente Blvd., Los Angeles, CA, 90049 contact number 310 826 2555. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practice. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the department of Health and Human Services. To file a complaint with our practice, contact Raphael Darvish, M.D. 11611 San Vicente Blvd., Los Angeles, CA, 90049 contact number 310 826 2555. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

   If you have any questions regarding this notice or our health information privacy policies, please contact Raphael Darvish, M.D. 11611 San Vicente Blvd., Los Angeles, CA, 90049 contact number 310 826 2555.

I hereby acknowledge that I have been presented with a copy of Concierge Medicine/LA's Notice of Privacy Practices.

Signature _____ Date _____

Printed Name _____

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 or arbitration proceeding. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on 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 related 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 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 if them, must be arbitrated including, without limitations, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of 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 communicate in writing to all parties. Each party shall select arbitration (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 contact. This immunity shall supplement, nit supplant, any other applicable statutory or common law. Either party shall have the absolute right arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and joiner 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 joiner any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provision of California law applicable to health care providers shall apply to disputes within arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code sections 3333.1 and 3333.2. Any party may bring before the arbitrations 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, or signature. It is the intent of this agreement to apply to all medical services rendered any time for any conditions.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here ._____(Patient's or Patient Representative's initials). Effective as the date of first professional services_____.

If any provision in this arbitration agreement is held invalid of 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: _____ _____

Patient's or **Patient** Representative's Signature Date

Patient Name : _____ If signing for patient, indicate relationship: _____

By: _____ _____

Physician or Authorized Representative Date

Physician Name
Raphael Darvish, MD
11611 San Vicente Blvd., Lobby Level
Los Angeles California 90049
T (310) 826-2555 F (310) 826-2552

Medical Group or Association Name
Skinpeccable
Concierge Medicine/LA