Patient Information Packet

Thank you for choosing our office! To serve you properly, we need the following information. Please take a moment to fill out the following forms as thoroughly as possible. Please Print. All information will be confidential.

Patient Name: _____ Date of Birth: _____ Age: _____

Mailing Address: _____ Email: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Sex: _____ Marital Status: _____ Social Security Number: _____

Language spoken: _____ Race: _____ Ethnicity (circle one): Hispanic Non-Hispanic

Primary Care Physician: _____ Phone number: _____

Referring Physician: _____ Phone number: _____

Pharmacy Name: _____ Phone number: _____

Notify in case of emergency: _____ Phone: _____ Relation: _____

Name of Primary insurance: _____ Insured's Name: _____

Insured's Date of Birth: _____

Name of Secondary insurance: _____ Insured's Name: _____

Insured's Date of Birth: _____

CURRENT MEDICATIONS (INCLUDE VITAMINS, SUPPLEMENTS, AND OVER THE COUNTER MEDS)

Name of Medication	Dose	How often taken	Start Date	Stop Date
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				

Patient Information Packet

Reason For Your Consultation:

_____

_____

MEDICAL HISTORY / CURRENT MEDICAL PROBLEMS (CHECK ALL THAT APPLY, FILL IN ANY OTHERS

- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Polymyalgia Rheumatica (PMR)
- ☐ Osteoporosis
- ☐ Spinal Stenosis
- ☐ Rotator Tendonitis / Tear
- ☐ Bursitis
- ☐ Fibromyalgia
- ☐ Lupus
- ☐ Prostate Problems
- ☐ Bladder Problems _____
- ☐ Kidney Problems
- ☐ Sjogren's Syndrome
- ☐ Chemical Dependency
- ☐ Aids
- ☐ Prostate Problem
- ☐ Last Bone Density Test? _____
- ☐ Broken bone(s)? _____
- ☐ _____

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Heart Disease: _____
- ☐ Heart Attack
- ☐ Atrial Fibrillation
- ☐ High cholesterol
- ☐ Emphysema / Asthma
- ☐ Reflux / GERD
- ☐ Stomach/GI problems: _____
- ☐ Depression
- ☐ Thyroid disorder
- ☐ History of tuberculosis ☐PPD positive
- ☐ Stroke
- ☐ Anemia
- ☐ Arthritis, type _____
- ☐ Cancer, type_____
- ☐ _____
- ☐ _____
- ☐ _____

MEDICATION ALLERGIES

NAME OF MEDICATION	TYPE OF REACTION
	☐ rash ☐ difficulty breathing ☐ stomach pain / vomiting ☐ other:
	☐ rash ☐ difficulty breathing ☐ stomach pain / vomiting ☐ other:
	☐ rash ☐ difficulty breathing ☐ stomach pain / vomiting ☐ other:

SURGERIES

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE

FAMILY HISTORY

FAMILY MEMBER	YEAR OF BIRTH	RA	Colon Cancer	Diabetes	Hypertension	Heart Disease	Other
FATHER	_____	☐	☐	☐	☐	☐	☐
MOTHER	_____	☐	☐	☐	☐	☐	☐
GRANDFATHER	_____	☐	☐	☐	☐	☐	☐
GRANDMOTHER	_____	☐	☐	☐	☐	☐	☐
SON	_____	☐	☐	☐	☐	☐	☐
DAUGHTER	_____	☐	☐	☐	☐	☐	☐
SISTER	_____	☐	☐	☐	☐	☐	☐
BROTHER	_____	☐	☐	☐	☐	☐	☐

Patient Information Packet

SOCIAL HISTORY / HABITS

□ Smoking: _____ packs/day □ Non-smoker □ Quit smoking in _____
□ Alcohol use: □Yes (drinks/week: _____) □ No
□ Married □ Widowed □ Divorced □ Single
□ Occupation: _____ □ Retired
□ I exercise regularly □ I exercise rarely □ I do not exercise □ Type exercise _____
□ I have traveled outside the United States in the past three months
□ Recreational drug use. Type: _____ □ Never

REVIEW OF SYMPTOMS: Please mark the symptoms you have been having recently.

GENERAL
- □fever
- □ chills
- □ night sweats
- □ dizziness
- □ fatigue
- □ weight loss
- □ weight gain
- □ Pain
- □ insomnia

RESPIRATORY
- □ shortness of breath
- □ chest pain
- □ cough
- □ coughing blood
- □ wheezing
- □ congestion

ENDOCRINE
- □ excessive appetite
- □ excessive sweating
- □ excessive thirst
- □ Heat/cold intolerance
- □ cold intolerance
- □ Hair loss
- □ Excess hair growth

PSYCIATRIC
- □ depression
- □ anxiety
- □ nervousness
- □ sadness
- □ frequent crying
- □ stress

MUSCULOSKELETAL
- □ hip pain
- □ shoulder pain
- □ joint pain
- □ muscle pain
- □ back pain
- □ neck pain

CARDIOLOGY
- □ chest pain
- □ palpitations
- □ leg cramp
- □ Lightheadedness
- □ heart murmur
- □ Chest pressure/discomfort

Genitourinary
- □ burning
- □ blood in urine
- □ urgency to urinate
- □ increased frequency
- □ leaking
- □ recurrent UTI
- □ lack of bladder control

ALLERGY
- □ Latex allergy
- □ Environmental allergies
- □ Immunodeficiency

EAR/NOSE/THROAT
- □ scalp tenderness
- □ dry mouth
- □ hair loss
- □ postnasal drip
- □ thrush
- □ jaw pain
- □ oral sores
- □ vision change
- □ cold
- □ Frequent sore throats
- □ Ear problems
- □ nosebleed
- □ Sinus problems

GASTROENTEROLOGY
- □ nausea
- □ heartburn
- □ vomiting
- □ diarrhea
- □ difficulty swallowing
- □ bloating/belching
- □ abdominal pain
- □ change in bowel habits
- □ blood in stool
- □ black tarry stool

ENDOCRINE
- □ excessive sweating
- □ excessive urination
- □ heat intolerance
- □cold intolerance

EYES
- □decreased vision
- □red eyes
- □ blurry vision
- □vision loss
- □ dry eyes
- □seasonal eye

INTEGUMENTARY
- □ Skin color changes
- □ Bruising
- □ Rash
- □ Hair changes
- □ skin cancer's
- □ Nail changes

BLOOD/LYMPH
- □ swollen glands
- □loss of appetite
- □ night sweats
- □ fevers
- □ easy bruising

Patient Information Packet

PLEASE READ CAREFULLY (and check boxes):

☐ I hereby authorize Dr. Hazan or Ventura Clinical Trials to provide full details of my medical history and treatment to
my referring physician or primary physician, including the results of HIV testing according to HIPAA regulations and to obtain my medication history from my pharmacy, my health plans and my other healthcare providers.

☐ I understand I will be expected to have a primary care physician for non-gastroenterology / hepatology medical care.

PLEASE TELL US HOW WE MAY CONTACT YOU (check one or more boxes):

☐ Leave messages at home.	☐Leave brief messages only.	☐ Leave detailed messages.
☐ Leave messages on cell phone.	☐ Leave brief messages only.	☐ Leave detailed messages.
☐ Leave messages at work.	☐ Leave brief messages only.	☐ Leave detailed messages.

☐ Speak to the following family members in my house:

1. _____ _____
2. _____ _____
   Name Relationship

Signature of Patient: _____ Date: _____

Billing and Insurance Policy

Telephone consultation fees are $250 per half hour, per patient. It is advised that you have all questions ready for Dr. Hazan ahead of time in order to maximize your consultation time. Should your consultation go over a half hour, the fee will be $100 every 15 minutes.

We will call to confirm your appointment at least 24 hours ahead of time. Failure to submit new patient forms, filled out in their entirety, 24 hours ahead of appointment time will result in delay or re-scheduling of your consultation.

Initials: _____

I have read and understand the HIPPA regulations in the office. A copy will be provided if I request one. I have had the opportunity to have my questions answered regarding the HIPPA guidelines.

Initials: _____

NOTICE TO CONSUMERS: Sabine Hazan M.D. is licensed and regulated by the Medical Board of California (800)633-2322:www.mbc.ca.gov

I have read, understand, and agree to all the items above.

Patients Signature: _____ Date: _____

Patient Information Packet

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW CAREFULLY

The Health Insurance Portability and Privacy Act of 1996(HIPAA) is a federal program the requires that all medical records and individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. HIPAA give you and your children, and or significant other new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that miss personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information, and how we may use and disclose this information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

*TREATMENT: Providing, coordinating or maintaining health care and related services by one or more health care providers. Examples of this would include a physical examination, consultation or referral.

*PAYMENT: Activities such as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a claim to your insurance company for payment.

*HEALTH CARE OPERATIONS: The business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and case management. An example would be internal quality assessment review.

Other uses and disclosures may include the following:

*We may collect and distribute non-identifiable health information by removing all references to individually identifiable information.

*We may disclose protected health information to another covered entity for any health care operations. An example of this would be laboratory or hospital outpatient procedures, and disclosures for certain public health purpose and required by law.

We may contact you at your home or other designated locations and leave a message or voicemail in person in reference to any items that assist the practice in carrying out our functions, such as appointment reminders, insurance items that any call pertaining to clinical care, including laboratory results. We may mail to your home or other designated location any items that assist the practice in carrying out our operations, such as appointment reminder cards or billing statements.

Any other uses and disclosures maybe only made with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the PRIVACY OFFICER.

Patient Information Packet

*The right to request restrictions on certain uses and disclosures of health information including those related to disclosures to family members, other relatives, close personal friends, or other persons identified by you. We are, however, not required to agree to request restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

The right to reasonable requests to receive confidential communications from us by alternative means or at alternative locations.

*The right to inspect and copy your health infuriation with written notification at time and date deemed appropriate by the Privacy Officer. A reasonable fee for copies will be charged.

* The right to request in writing an amendment for corrections or erroneous or incomplete information in your medical record.

The right to receive and accounting of health information disclosures

The right to request restriction of use or disclosure of health information. (HS Medical, not required to agree)

This notice is effective April 14th, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect.

If you feel that your privacy protections have been violated, you have the right to file a formal, written complaint with our office or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. Please contact us for more information by asking to speak to our Privacy Officer. Send written inquires, "Attention Privacy Office".

For more information about HIPAA contact:

The U.S. Department of Health and Human Services Office of Civil Rights
200 Independence Avenue S.W.
Washington, D.C. 20201

I have received a copy of the Notice of Privacy Practices, prepared by Sabine Hazan-Steinberg M.D. Gastroenterology/Hepatology and required by the Health Insurance Portability and Privacy Act.

Signature: _____ Date: _____

Patient Information Packet

Sabine Hazan-Steinberg, M.D.

1835 Knoll Drive
Ventura, CA 93003
Telephone: (805)339-0549
Fax: (805)642-1540

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide *all* information may invalidate this authorization. Please fill out one each for multiple individuals who are authorized to receive your medical information. (Primary Care Physician, Employer, Spouse, Relative, Friend, or Insurance Company)

Name of Patient: _____ DOB:_____

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize: _____
To release to: _____
The following information:

a. ____ All health information pertaining to my medical history, mental or physical condition and treatment received OR
b. ____ Only the following records or types of health information (including any dates):
   _____
   _____
   _____
c. ____ I specifically authorize release of the following information (check as appropriate):
   ____ Mental health treatment information
   ____ HIV test results
   ____ Alcohol/drug treatment information

This authorization expires: _____

Signature: _____ Date: _____

If signed by someone other than the patient, state your legal relationship to the patient:
Relationship: _____ Name: _____

Patient Information Packet

Sabine Hazan-Steinberg, M.D.

1835 Knoll Drive
Ventura, CA 93003
Telephone: (805)339-0549
Fax: (805)642-1540

Payments

I _____ understand that my credit card will be charged $250 just prior to my consultation. If my consultation goes over a half hour, my card will be charged an additional fee at the rate of $100 per 15 minutes.

Patient Name: _____

Current Date: _____

Name as is on Credit Card: _____

Credit Card Billing Address:

_____, _____, _____, _____
Street City State Zip

Credit Card Number: _____

Security Pin on Back of Card: _____

Would you like a copy of this form for your files? ☐ YES ☐ NO

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 or arbitration proceedings. 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 bron 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 limitation, 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 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, nit supplant, any other applicable statutory or common law.

Either party shall have the absolute right ti 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 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 once 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 condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is Effective as of the date of first medical services.

_____
Patient's or Patient Representative's Initials

If any provision if 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)

By: _____ _____
Physician's or Authorized Representative's Signature (Date)

By: _____
Print Patient's Name

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

_____
(If Representative, Print Name and Relationship to Patient)

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