Patient Information

Name: ---------- **Phone: 1)** ----------

Date of Birth: ----------/--------/---------- **Phone: 2)** ----------

Address: ---------- **Language:** ----------

Marital Status: (S)------(M)-------(D)-------(W)----- **SS#:** ---------- **Email:** ----------

Race: ( ) White ( ) Black/African American ( ) Hispanic ( ) Asian ( ) Pacific Islander ( ) Native Hawaiian

( ) American Indian ( ) Other: ( ) Decline

Ethnicity: ( ) Hispanic/Latino ( ) Not Hispanic/Latino ( ) Other:

Medical History:

Yes	No		Yes	No		Yes	No	
		Hypertension			Anemia			Thyroid Problem
		Diabetes			Depression			Sinus Allergy
		High Cholesterol			Anxiety			Migraine
		Heart Disease			Cancer			Seizure/Epilepsy
		Stroke			Osteoporosis			Prostate Problem
		Arthritis			Liver Disease			STD's
		Back Problem			Kidney Disease			Other:
		Asthma/Emphysema			Bleeding Disorder			

Medications			**Allergy**	**Severity**
Name	Dose	Frequency	1.	
1.			2.	
2.			3.	
3.			**Social History**	
4.			Yes / No	
5.				***Illicit Drugs Use***
6.			Name:	
7.				***Alcohol***
8.			If yes, ------- Drinks x ------- Years	
9.				***Smoker***
10.			If yes, ------ Pack(s) x ------- Years	

Family History: 1. ---------- **Surgical History:** 1. ----------

2. ---------- 2. ----------

Patient Signature: ---------- **Date:** ---------/-------/----------

MOHAMED S. ALI, M.D.
Internal Medicine
10165 Foothill blvd #26
Rancho Cucamonga, CA 91730

PATIENT QUESTIONAIRE

I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis:

_____

_____

II. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

_____

_____

III. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home:

_____

_____

IV. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL":

YES: _____ NO: _____

V. Please print the telephone number, if any, where you want to receive calls about your appointments, lab, and x-ray results, or health care information if other than your home phone number:

(___) ___-____.

VI. Can confidential messages (i.e. appointment reminders) be left on your home answering machine or voicemail?

YES: _____ NO: _____

VII. If you do not have a voicemail, can a confidential message be left at your place of employment?

YES: _____ NO: _____

Patient Name :_____(guardian if under 18 years)

_____ _____

Patient/Guardian Signature Date

Mohamed Ali, M.D.
10165 Foothill Bl. STE 26
Rancho Cucamonga, CA 91730
(909) 481-0800

Patient Partnership Plan

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your ***best possible health*** requires a "partnership" between you and your doctor. As our " partner in health," we ask you to help us in the following ways:

Schedule Visits with My Doctor for Routine Physical Exams and Other Recommended Health Screenings

I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (mammogram, immunizations, pap smears etc). **These health screenings are tests that can help detect life-threatening disease and conditions.** If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

Keep Follow-up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order test, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do Not Hear the Results of Labs and Other Test

I understand that my physician's goal is to report my labs and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

Inform My Doctor if I Decide Not to Follow His or Her Recommended Treatment Plan

I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that not following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide not to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, **at any time**, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

Patient Signature	Date	Physician Signature

ACKNOWLEDGEMENT

Physician: _____ Telephone: _____

Address: Mohamed Ali, M.D.
10165 Foothill Bl. STE 26
Rancho Cucamonga, CA 91730
(909) 481-0800

Patient's Name: _____ DOB: _____

Address: _____ Telephone: _____

_____

_____

Advanced Directives

This acknowledgment that the physician, or one of his/her staff members, has provided me information concerning Advanced Directives.

1. I am age 18 or older. (Circle one) **Yes** **No**

2. I realize that I have the option of putting together Advanced Directives for my healthcare. My physician has provided me written information concerning these Advanced Directives. I understand that it is my responsibility to provide my doctor(s) with any documents that are required to carry out my Advanced Directives.

3. I am aware that Advanced Directives may be any one of the following:

   a. A Durable Power of Attorney for Health Care.
   b. The Declaration in the A natural Death Act – Ex. A Living Will
   c. I may write down my wishes on a piece of paper so that my family may use the document, in deciding my medical treatment, in the event I am unable to do so.

Patient's Signature: _____ **Date:** _____

This document will become part of my medical record.

Mohamed Ali, M.D.

10165 Foothill blvd. # 26 Rancho Cucamonga, CA 91730

Privacy Officer: Denise

Phone:(909)481-0800

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient

Name and Address of Patient: _____

_____

Por la presente reconozco que he recibido una copia del Aviso de esta práctica médica de prácticas de privacidad. Además, reconozco que una copia del aviso actual será fijada en la zona de recepción, y que una copia de la Notificación de Prácticas de Privacidad modificado estará disponible en cada cita.

Firmado: _____ Fecha: _____

Imprimir Nombre: _____ Teléfono: _____

Si no está firmada por el paciente, por favor indique la relación:

☐ El padre o tutor del paciente menor de edad

☐ Tutor o curador de un paciente incompetente

Nombre y dirección del paciente: _____

_____

_____

Advance Directives – The Patient's Right to Decide

All adult individuals in hospitals, nursing homes and other health care settings have certain rights. For example, you have a right to confidentiality of your personal and medical records and to know what treatment you will receive.

You also have another right. You have the right to fill out a paper known as an "advance directive". The paper says in advance what kind of treatment you want or do not want under special, serious medical conditions – conditions that would prevent you from telling your doctor how you want to be treated. For example, if you were taken to a hospital in a coma, would you want the hospital's medical staff to know your specific wishes about decisions affecting your treatment?

This article answers some questions related to a federal law that took effect in 1991 that requires most hospitals, nursing facilities, hospices, home health care programs and health maintenance organizations (HMO's) to give you information about advance directives and your legal choices in making decisions about medical care. The law is intended to increase your control over medical treatment decisions.

The information in this article can help you make decisions in advance of treatment. Because this is an important matter, however, you may wish to talk to family, close friends and your doctor before deciding whether you want an advance directive.

Finally, it is important to remember that state laws differ about legal choices available to individuals for treatment options that can be honored by hospitals and other health care providers and organizations. These health care professionals should have information for you on your state's advance directive law.

What is an Advance Directive?

Generally, an advance directive is a written statement, which you complete in advance of serious illness, about how you want medical decisions made. The two most common forms of advance directives are:

- Living Will
- Durable Power of Attorney for Health Care

An advance directive allows you to state your choices for health care or to name someone to make those choices for you, if you become unable to make decisions about your medical treatment. In short, an advance directive can enable you to make decisions about your future medical treatment. You can say, "yes" to treatment you want, or say "no" to treatment you don't want.

What is a Living Will?

A Living Will generally states the kind of medical care you want (or don't want) if you become unable to make your own decision. It is called a Living Will because it takes effect while you are still living.

Most states have their own living will forms, each somewhat different. It may also be possible to complete and sign a pre-printed living will form available in your own community, draw up your own form, or simply write a statement of your preferences for treatment. You my also wish to speak to an attorney or your physician to be certain you have completed the living will in a way that your wishes will be understood and followed.

What is a Durable Power of Attorney for Health Care?

In many states a Durable Power of Attorney for Health Care is a signed, dated and witnessed paper naming another person such as a husband, wife, daughter, son, or close friend as you agent or proxy to make medical decisions for you if you should become unable to make them for yourself. You can include instructions about any treatment you want or wish to avoid. Some states have specific laws allowing a health care power of attorney and provide printed forms.

Which is Better: A Living Will or a Durable Power of Attorney for Health Care?

In some states, laws may make it better to have one or the other. It may also be possible to have both, or to combine them in a single document that describes treatment choices in a variety of situations (ask your doctor about these) and names someone (called your agent or proxy) to make decisions for you, sho8uld you be unable to make decisions for yourself.

NOTICE OF PRIVACY PRACTICES

Mohamed Ali MD

10165 Foothill Blvd, STE 26

Rancho Cucamonga, CA 91730

Privacy Officer: Denise

Phone: (909) 481-0800

Effective Date: January 1, 2014

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. **Treatment.** We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.

2. **Payment.** We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. **Health Care Operations.** We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality and security of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan, healthcare clearinghouse, or one of their business associates, California law prohibits all recipients of healthcare information from further disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population- based efforts to improve health or reduce health care costs, protocol development, case management or care coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, their activities related to contracts of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts. ***[Participants in organized health care arrangements only should add: We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.]***

4. **Appointment Reminders**. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.]
5. **Sign In Sheet.** We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
6. **Notification and Communication with Family**. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you have instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
7. **Marketing**. Provided we do not receive any payment for making these communications, we may contact you to encourage you to purchase or use products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans we participate in,
We may receive financial compensation to talk with you face-to-face, to provide you with small promotional gifts, or to cover our cost of reminding you to take and refill your medication or otherwise communicate about a drug or biologic that is currently prescribed for you, but only if you either: (1) have a chronic and seriously debilitating or life-threatening condition and the communication is made to educate or advise you about treatment options and otherwise maintain

adherence to a prescribed course of treatment, or (2) you are a current health plan enrollee and the communication is limited to the availability of more cost-effective pharmaceuticals. If we make these communications while you have a chronic and seriously debilitating or life threatening condition, we will provide notice of the following in at least 14-point type: (1) the fact and source of the remuneration; and (2) your right to opt-out of future remunerated communications by calling the communicator's toll-free number. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any financial compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. **Sale of Health Information**. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.
9. **Required by Law**. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
10. **Public Health.** We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
11. **Health Oversight Activities**. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.
12. **Judicial and Administrative Proceedings**. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
13. **Law Enforcement**. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
14. **Coroners**. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.
15. **Organ or Tissue Donation**. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
16. **Public Safety**. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
17. **Proof of Immunization**. We will disclose proof of immunization to a school where the law requires the school to have such information prior to admitting a student if you have agree to the disclosure on behalf of yourself or your dependent.
18. **Specialized Government Functions**. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.