When was the Last Time Your Doctor Made a House Call?

NEW PATIENT INTAKE

Part 1 of 2

(Completion of Part 1 is mandatory)

We appreciate you providing us with the most complete, up-to-date information available before the initial appointment with the Medical Provider. In doing so, we are able to provide the patient the most comprehensive and highest-quality care.

We kindly ask that all sections that are highlighted be completed. If sections of this form are not complete, services may be delayed.

Sincerely,

Mobile Physician Associates

How did you hear about Mobile Physician Associates?:

☐ Online	☐ Health Professional	☐ Friend
☐ Flyer	☐ Facility Personnel	☐ MPA
☐ Patient Other _____		

MOBILE PHYSICIAN Associates

When was the Last Time Your Doctor Made a House Call?

Patient Information Forms

(Please fill out completely)

PERSONAL

Name: ☐ Mr. ☐ Mrs. ☐ Ms. _____

Date of Birth: _____ Social Security Number: _____

Sex: ☐ M ☐ F Marital Status: ☐ M ☐ S ☐ W ☐ D

Spoken Language: _____ Type/Name of Residence: _____

Address of Residence: _____ (Street/Apt Number/Room #)

_____ (City/State/Zip)

_____ (Phone)

Billing Address: _____ (Street/Apt Number)

_____ (City/State/Zip)

CONTACT

Primary Contact Name: _____

Relationship to Patient: _____ Primary Contact For:

Home Phone: _____ ☐ Appointments

Cell Phone: _____ ☐ Billing

Email Address: _____ ☐ Emergency

Medical Power of Attorney: Financial Power of Attorney:

Name: _____ Name: _____

Phone: _____ Phone: _____

Fax: _____ Fax: _____

Email: _____ Email: _____

MOBILE PHYSICIAN Associates

When was the Last Time Your Doctor Made a House Call?

FINANCIAL

Medicare: ☐ Yes ☐ No

Primary Insurance:	Secondary Insurance:
(i.e. Medicare, etc.)	(i.e. Supplemental/PPO)
Plan Name: _____	Plan Name: _____
ID Number: _____	ID Number: _____
Beneficiary: _____	Beneficiary: _____
Policy Holder: _____	Policy Holder: _____
Phone Number: _____	Phone Number: _____

Please include photo copies of the front and back of both insurance cards.

MEDICAL HISTORY

Current Primary Care Physician:	Caretaker(s):
Name: _____	Name: _____
Phone: _____	Phone: _____
Fax: _____	Fax: _____

Pharmacy: ☐ Mail Order (Check if Yes)

Address: _____

Phone: _____

Fax: _____

When was the Last Time Your Doctor Made a House Call?

AUTHORIZATION RESPONSIBILITY AGREEMENT

1) I hereby authorize my insurance company to pay Med Institute, Inc. directly for all medical services rendered.

2) I clearly understand that Med Institute Inc. is not an approved provider of Medi-Cal as a primary insurance. I clearly understand that it is my responsibility to understand what my insurance does and does not cover.

3) I clearly understand that I am responsible for any patient balance per the explanation of benefits (EOB) from my primary and/or secondary insurance carrier (i.e. Co-Pay, Co-Insurance and/or the yearly Medicare Deductible, per Medicare regulations, etc).

4) I clearly understand that Med Institute, Inc., requires 6 hours notice if I am unable to make my scheduled appointment for any reason. I clearly understand that I may be billed a fee of $150.00 if: I am not available for my visit, I refuse the visit after the provider has arrived or I cancel/reschedule without 6 hours notice of my scheduled appointment time.

5) I clearly understand that a $35.00 fee will be billed when checks are returned by the bank.

6) A photocopy of this assignment shall be considered as valid as the original.

Signature: _____ Date: _____

PERMIT FOR TREATMENT

I/We, hereby authorized Med Institute, Inc. and/or Staff to render whatever services deemed necessary for the care of _____, and I/we agree to assume all financial obligations incurred for care.

Signature: _____ Date: _____

MOBILE PHYSICIAN Associates

When was the Last Time Your Doctor Made a House Call?

PATIENT EXTENDED SIGNATURE AUTHORIZATION

Statement To Permit Payment Of Medicare
Benefits To Supplier, Physician, or Patient

New Beneficiary Signature Regulations in effect since April 1, 1932, allows physicians (or other suppliers in most cases) to obtain from the beneficiary and retain in their files, a lifetime signature authorization for the physician or supplier to submit assigned or unassigned claims in the beneficiary behalf.

The beneficiary must sign a brief statement as follows:

Name of Beneficiary _____ Health Insurance Claim Number _____

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to Med Institute, Inc. (DBA Mobile Physician Associates) for any services furnished to me by Med Institute, Inc. I authorized any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits of the benefits payable for related services."

Once the physician/supplier has obtained the patient's one-time authorization, he may submit any later Medicare Claims, on either an assigned or unassigned basis, without obtaining any additional signatures of the patient.

Signature of the Patient _____ Date _____

MOBILE PHYSICIAN Associates

When was the Last Time Your Doctor Made a House Call?

HIPAA PRIVACY RULE PATIENT AUTHORIZATION AGREEMENT

Authorization for the Disclosure of Protected Health Information
for Treatment, Payment, or Healthcare Operations (§164.508(a))

I understand that as part of my health care, Med Institute Inc. originates and maintains health records describing my health history, symptoms, examination and test results diagnoses, treatment and any plans for future care or treatment. I understand that this Information serves as:

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

I have been provided with the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review the ***Notice of Privacy Practices*** prior to signing this authorization. I authorized the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

I understand that:

- I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operation by other covered entities.
- I may revoke this consent in writing at any time, except to the extent that Alex Foxman, M.D., Inc. has already taken action in reliance thereon. I understand that this action may limit my future treatment options.

_____ _____

Signature of Patient or Legal Representative Witness Date

_____

Printed Name of Patient or Legal Representative Witness

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 Provability 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 for the purpose of Treatment, Payment and Health Care Operations:

1. ***Treatment*** - Includes sharing medical data with other providers, making referrals, and placing lab and pharmacy orders.
2. ***Payment*** - Includes activities involved in determining eligibility, billing of claims, and collection of charges.
3. ***Health Care Operations*** - Includes the necessary administrative and business functions of our office.

Uses 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 of 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 Worker's Compensation and similar programs.

NOTICE OF PRIVACY PRACTICES (CONT'D)

Your right 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 of 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 and billing records, but not including psychotherapy notes. *You **MUST** submit your request in writing to: Med Institute, Inc. 9400 Brighton Way, Suite 410, Beverly Hills, CA 90210.*
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. *You **MUST** submit your request in writing to: Med Institute, Inc. 9400 Brighton Way, Suite 410, Beverly Hills, CA 90210.* 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 Practices. 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 or our office manager.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our Office Administrator. All complaints must be submitted in writing to: *Med Institute, Inc. ATTN: Office Administrator, 9400 Brighton Way, Suite 410, Beverly Hills, CA 90210.* You will in no way be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures that are not identified by this notice or permitted by applicable law. *It is our mission and continuous goal to provide you with the best care and service possible:* If you have any questions regarding this notice, our health information privacy policies, or any other issue, please contact our office at any time.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have the right to receive a ***Notice of Privacy Practices*** from the above-named practice.

_____ _____

Signature of Patient or Representative Date

If a personal representative signs this authorization on behalf of the individual, complete the following:

_____

Printed Name

_____

Relationship to Individual

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 right 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 up on 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 with 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 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.

PHYSICIAN–PATIENT ARBITRATION AGREEMENT (cont)

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 at 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 or 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: _____

Patient Name (Please Print)

By:_____ _____

Patient / Patient's Representative's Signature Date

By:_____ _____

Physician's or Authorized Representative's Signature Date

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

FOR: Mobile Physician Associates
Med Institute, Inc.
9400 Brighton Way, Ste 410
Beverly Hills, CA 90210

MOBILE PHYSICIAN Associates

When was the Last Time Your Doctor Made a House Call?

Chronic Care Management Program

Dear Patient,

You have been selected for a new program from Medicare that provides some really great services to help you manage your chronic conditions. This program is available to Medicare patients with 2 or more Chronic Conditions. Your doctor believes that this program could really help to manage your Chronic Conditions.

Here are the benefits of the program:

- We'll create a Care Plan that is custom-designed to meet your goals. (You will receive a copy)
- We'll do a full assessment of your health needs.
- Every month, we'll check in to make sure things are going well.
- You'll have access to a healthcare provider who can address your chronic conditions 24/7.
- Hopefully we'll be able to address any issues outside of the office, resulting in fewer office visits and fewer hospital admissions.

Before we start, we need you to consent to the following:

- We may share your information with your other providers and this may be done electronically. This will allow all those involved with your care to stay up-to-date with your progress in this program.
- Only one provider can provide this service to you during a 30-day period.
- You agree that ***Mobile Physician Associates*** will be that one provider.
- You can cancel or revoke this service at any time by talking to our staff. We'll provide you a form to sign if you decide to cancel.
- Depending on your insurance, you may be billed for a small portion of the CCM Service. In many cases, the service is free without a Co-pay. In the long term, this service should help to reduce your overall healthcare costs and will save money in the long term.

Please sign here to enroll in the program!

Print Name: _____ Date of Birth: _____

Best phone # that I can be reached: (_____) _____- _____

Patient Signature: _____ Today's Date: _____

(Optional): Legal Rep or POA: _____ Signature: _____

(Office use only) Diagnosis to Manage in CCM Program: _____

9400 Brighton Way, Suite 410 Beverly Hills, CA 90210
Phone: (310) 256-2426 / Fax: (310) 954-9373
www.MyMobilePhysician.com

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 1/1/2016)*

First follow these orders, then contact Physician/NP/PA. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. **POLST complements an Advance Directive and is not intended to replace that document**.

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: *(optional)*

A — CARDIOPULMONARY RESUSCITATION (CPR): *If patient has no pulse and is not breathing.*

If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.

Check One

☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A **requires** selecting Full Treatment in Section B)

☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

B — MEDICAL INTERVENTIONS: *If patient is found with a pulse and/or is breathing.*

Check One

☐ **Full Treatment – primary goal of prolonging life by all medically effective means.**
In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.

☐ ***Trial Period of Full Treatment.***

☐ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.**
In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ ***Request transfer to hospital only if comfort needs cannot be met in current location.***

☐ **Comfort-Focused Treatment – primary goal of maximizing comfort.**
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Additional Orders: _____

_____

C — ARTIFICIALLY ADMINISTERED NUTRITION: *Offer food by mouth if feasible and desired.*

Check One

☐ Long-term artificial nutrition, including feeding tubes. Additional Orders: _____

☐ Trial period of artificial nutrition, including feeding tubes. _____

☐ No artificial means of nutrition, including feeding tubes. _____

D — INFORMATION AND SIGNATURES:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated _____, available and reviewed →
☐ Advance Directive not available
☐ No Advance Directive

Health Care Agent if named in Advance Directive:
Name: _____
Phone: _____

Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)
My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Print Physician/NP/PA Name:	Physician/NP/PA Phone #:	Physician/PA License #, NP Cert. #:
Physician/NP/PA Signature: *(required)*		Date:

Signature of Patient or Legally Recognized Decisionmaker
I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Print Name:		Relationship: *(write self if patient)*
Signature: *(required)*	Date:	**FOR REGISTRY USE ONLY**
Mailing Address (street/city/state/zip):	Phone Number:	

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009, 4/1/2011 or 10/1/2014 are also valid