

Patient Information

Full Legal Name: _____

Home Address:

Date Of Birth: _____ SSN: _____

Home Phone Number: _____ Work Phone # _____

Cell Phone Number: _____ Fax #: _____

E-mail Address: _____

Best Way to reach you: e-mail or phone __Spouse Name: _____

Best Time to reach you: _____ Okay to call at Work: _____

Emergency Contact- Name: _____ Phone # _____

Primary Reason for your visit today

Referred by:

1. Friend/family

Name- _____

Address- _____

2. Magazine AD **circle one or more**

Latest Who What Where Los Feliz Ledger LA times other

3. Internet ACAM A4M Health excel ALMC website

4. Other _____

Consent for treatment

I hereby consent to and authorize the administration of all emergency and non-emergency diagnostic and therapeutic treatment for me or my minor child that may be necessary in the judgment of the attending physician and/or medical personnel. It is agreed that because of differences in human constitution and response, it is in no way possible to warrant the outcome of such medical care and service.

Print name _____ Patient Signature: _____

Date signed _____

Angel Longevity Medical Center Financial Policy

All services must be paid in full at the time of service.

We do accept American Express, Visa, Master card or Discover card for all services and products.

We also offer patient financing through *Care Credit*. Ask the receptionist if you qualify.

We also accept Debit cards so long as they have the Visa or MasterCard logo.

We accept personal checks as well as business checks.

We do not accept Medi-Cal, Medi Care or any other form of private insurance at this time. This includes PPO, HMO, Healthy families or Family Pact program. However we do provide a Superbill with all information so you can bill your own insurance for possible reimbursement.

Certain laboratory tests as ordered by the Doctor are performed at Quest Diagnostics a nationwide laboratory. Fees for these laboratories are collected at the time of specimen collection and must be paid at the time the tests are done. We will pass on our low lab fees directly to you, but we expect payment on the day the labs are rendered. There are several tests that your insurance carrier may not deem medically necessary and therefore will not reimburse. .

We also use Meridian Valley Laboratory for our Hormone testing as well as Diagnos tech Laboratory along with other labs. For these Laboratories you mail the payment directly to them.

We reserve the right to charge you a full visit if you fail to show up for your appointment. We regret we must charge for missed or changed appointments, unless we are given one full business day's notice. (Business days are Monday through Friday). For changes within one full business day you will be responsible for the full service fee. There is no charge if we are given 24-hour notice.

We have a NO REFUND Policy. If you have made advance payments for a wellness program and then decide to not do it then you would forfeit the payment made.

I have read and understand the above and agree to follow the Angel Medical Center financial policy.

Signature _____ date _____

Print Name _____

NOTICE OF PRIVACY PRACTICES

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

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on 3/1/2007 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Angel Medical Center. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: **We will not use your health information for marketing purposes unless we have your written authorization to do so.**

National Security: The **health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances.** If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: **We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.**

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: **Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.)** There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be \$1 for each page and the staff time charged will be

\$ 20) per hour including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: **You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete.** Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: **You have the right to receive a list of non-routine disclosures we have made of your health care information.** (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. *(Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)*

Restrictions: **You have the right to request that we place additional restrictions on our use or disclosure of your health information.** We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us. In writing. Request a Complaint Form from our Privacy Officer. **We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.**

HOW TO CONTACT US

Practice Name: **Angel Longevity Medical Center**

Privacy Officer- **Alejandra Iglesias**

Telephone: **323-661-7661**

Fax- **323-661-0747**

E-Mail: **info@angelmedcenter.com** Address: **1212 North Vermont Avenue, #101, Los Angeles, CA 90029**

Privacy Rule Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (164.506(a))

I, _____ Understand that as part of my health care, Angel Longevity Medical Center, 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 mean 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 a copy and understand the **Notice of Privacy Practices** that provides a more complete description of information uses and disclosures.

- I have the right to review Angel Longevity Medical Center, Inc. Notice of Information Practice prior to signing this consent;
- That Angel Longevity Medical Center, Inc. reserve the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Angel Longevity Medical Center, Inc. Is not required by law to agree to the restrictions requested;
- I may revoke this consent in writing at any time, except to the extent that Angel Medical Clinic, Inc. Has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my protected health information:

_____ Accepted _____ Denied

Signature of patient or Legal Representative Witness _____

Print Name of patient of Legal Representative Witness _____

Date: _____

Anju Mathur, M.D.
Angel Longevity Medical Center
1212 N. Vermont Ave, Suite 101
Los Angeles, C.A 90029
(323) 661-7661; Fax (323) 661-0747

About Our Office

The following information about some of our office policies will help you to become better acquainted with the way the office works.

Office Hours: Monday, Wednesday, Friday: 10:00 a.m. to 6:00 p.m.
Tuesday and Thursday: 10:00 a.m. - 5.00 p.m.

Telephone calls to the doctor: Unless in an acute emergency you will not be able to talk to the doctor during office hours. Please leave your question with the office staff. Complex medical issues require an office visit or at least a telephone consultation at regular fees.

Emergencies: In case of a serious medical emergency call 911 or go directly to the nearest emergency room. If you need to reach the doctor outside our usual office hours, call (323) 661-7661 and leave a message with the operator and the doctor will return your phone call as soon as possible.

Hospital Privileges: Dr Mathur does not currently practice hospital medicine. Should you require hospital care, we do have a wide circle of medical consultants to whom we can refer you. Nevertheless we encourage you to stay connected with a physician who does have hospital privileges.

Billing: Fees must be paid when services are rendered. We will provide you with a superbill that has all information your insurance carrier needs to reimburse you. If you are not sure whether a service is covered by your insurance, we encourage you to call your carrier for authorization in advance.

Lab fees: There is a \$20.00 handling fee for each lab visit and a \$40.00 fee for each venipuncture. We will pass on our low lab fees directly to you, but we expect payment on the day the labs are rendered. There are several tests that your insurance carrier may not deem medically necessary and therefore will not reimburse. .

Lab results: We will only call you with the results of blood tests or other lab if they contain critical values that need immediate attention. Otherwise we will discuss lab results during your next doctor visit. Make sure to book a follow up appointment whenever you have blood drawn or any other lab procedure performed.

Changing or canceling appointments: Please let us know as early as possible if you need to change your doctor appointment. We regret we must charge for missed or changed appointments, unless we are given one full business day's notice. (Business days are Monday to Friday). For changes within one full business day you will be responsible for the full service fee.

Renewal of medications: Unless you schedule a follow-up visit every six to twelve months, depending on your diagnosis, we cannot fill your prescription. Renewal of medication should be done well in advance. Except in emergencies we do not refill medication after office hours when your medical record is unavailable for review. To get refills please have your pharmacy **fax** us a refill request at (323) 661-0747.

Supplement orders: You can reorder your supplements by calling our office 323-661-7661 or going on the Internet to Ultralifeinc.com.

Parking: You can park in our building (entrance is up the driveway of the building).

The meter parking on the street has a 2-hour time limit. Sorry we do not validate. There is no street parking after 4 pm.

We welcome any suggestions you may have about ways we can improve our service to you. Should you have questions please feel free to ask our staff.

I have read and agree to abide by the above policies.

Signature: _____

Date: _____

Angel Longevity Medical Center

Age: _____

Name: _____ DOB _____ Date: _____

Concerns (Rank by priority): Onset / Frequency / Severity

- 1. _____
- 2. _____
- 3. _____
- 4. _____

(PLEASE bring ALL medications, vitamins, and supplements that you are currently taking to your first appointment.)

List ALL medications that you are currently taking.

| Medication | Dosage and Frequency | Reaction |
|------------|----------------------|----------|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |
| 4. _____ | _____ | _____ |

What Vitamins, remedies, and supplements are you taking now?

| | | | |
|-------|-------|-------|-------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Allergies (Medication)

Current Symptom List

Are you experiencing any of the following symptoms?

OVERALL:

- headaches
- blurred vision
- unusual thirst
- unusual hunger
- high stress
- low ability to tolerate stress
- irritability
- mood swings
- anxiety
- depression
- mental fatigue
- fatigue
- dizziness
- decreased hearing ability

RESPIRATORY/CARDIOVASCULAR:

- wheezing
- coughing
- shortness of breath
- runny nose
- sore throat
- itchy eyes
- chest pain
- chest heaviness
- radiating symptoms down arms
- trouble swallowing

SKIN:

- skin problems
- changes in any moles, skin blemishes
- questions about any moles or skin blemishes
- swollen lymph nodes
- toe nail problems, foot fungus or foot pain

GU:

- sexual difficulty (erection/orgasm difficulties) (*circle*)
- any changes in bowel movements
- red or black or sticky or tarry stools (*circle*)
- any problem with urine stream, flow, burning, incontinence
- irregular menstrual periods, spotting?
- excessively painful, heavy menstrual periods

GI:

- bloating, gas, burping
- diarrhea
- constipation
- hemorrhoids
- fissures or pain with bowel movements
- pain anywhere in abdomen

CNS

- tingling
- muscle weakness
- paralysis
- headaches
- numbness
- dizziness

MUSCULOSKELETAL-JOINT

Pain anywhere (*please describe: when, where, what makes it worse or better*)

OTHER: _____

Present and Family History

| Illnesses | Past | Present | Self | Family Members who have had these illnesses |
|-------------------------------------|------|---------|------|---|
| Heart Disease | | | | |
| High Blood Pressure | | | | |
| Cancer (Type) | | | | |
| Diabetes | | | | |
| Lung or Respiratory Disease | | | | |
| Hepatitis | | | | |
| Intestinal Dis / Diverticulosis | | | | |
| Thyroid Disease | | | | |
| Arthritis | | | | |
| Liver Disease | | | | |
| Kidney Disease | | | | |
| Gall Bladder Disease Gall Stones | | | | |
| Epilepsy | | | | |
| Venereal Disease | | | | |
| Blood Transfusion | | | | |
| Radiation Therapy | | | | |
| Chemo Therapy | | | | |
| Other: | | | | |

Please list any surgeries or hospital stays you have had and their approximate date/year:

