Dr. John C Hoefs
16305 Sand Canyon Ave
Suite # 220
Irvine CA 92618
Ph: 949-748-7474
Fax: 949-272-5858

Today's Date: _____
(mm/dd/yyyy)

Name (Last, First): _____ **Date of Birth:** _____

Sex: | | M | | F **Social Security #:** _____ **Marital Status:** | | Single | | Married | | Other

Employment Status: Employed: |__| Full-time Student: |__| Part-time Student: |__| Retired: |__|
Other: | |

Home Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work:** _____ **Cell:** _____

Employer: _____

City: _____ **State:** _____ **Zip:** _____

Occupation: _____

Emergency Contact: _____ **Relationship to Patient:** _____

Phone: _____

Who may we thank for referring you: _____ **Pri Care Doctor:** _____

INSURANCE INFORMATION

PRIMARY Insurance: _____ Group #: _____

ID#: _____ Co-pay: $ _____

SECONDARY Insurance: _____ Group #: _____

ID#: _____

Is someone else responsible for payment: |__| No |__| Yes- Subscriber's Name: _____

Subscriber's Date of Birth: _____ Relationship to Patient: _____

Responsible Party's Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

VISIT INFORMATION

Reason for this visit: ( ) Medical Problem ( ) Second Opinion ( ) Consult

Describe your condition/major complaint_____

Date of injury or onset of problem_____

If Job related, who can authorize your treatment_____

If Job related, your Company's Insurance Carrier_____ Phone_____

Referring Physician: _____ City_____ Phone_____

MEDICAL RECORDS RELEASE/ASSIGNMENT OF BENEFITS

I hereby authorize this office to release any necessary information for the purpose of payment of insurance claims. I hereby assign insurance payments directly to this office otherwise payable to the insured. I understand that I am financially responsible for all charges whether or not paid by my insurance. I agree to allow a copy of this authorization to be used in place of an original.

Signature of Patient:_____ Date:_____

Signature of Insured:_____ Date:_____

Signature of Parent (If patient is a Minor):_____ Date:_____

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NOTICE OF PRIVACY PRACTICES

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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO THIS OFFICE AND THIS PROTECTION BECAME EFFECTIVE ON APRIL 14, 2003 THROUGH APPLICABLE FEDERAL AND STATE LAWS.

USES and DISCLOSURES

Treatment. Your health information may be used by staff members or disclosed to other health professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment, or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your heath information may be used as necessary to support the day-to-day activities and management of John C. Hoefs, MD. For example, we may use a sign in sheet at the registration desk where you will be asked to sign your name. We may also call your name in the waiting room when you doctor is ready to see you. We may use your name, or disclose your protected health information, as necessary, to contact you by telephone or mail to inform you of lab results, or appointment information. We will share your protected health information with third party "business associates" that perform various activities (e.g. billing and transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that protects the privacy of your protected health information.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with governmental mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information, or its use for any purposes other than those listed in this document, requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you must submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

ADDITIONAL USES OF INFORMATION

Others Involved in your healthcare. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such disclosure, we may disclose such information as necessary if we determine that it is in your best interest, based on our professional judgment to notify or assist in notifying a family member, personal representative, or any other person that is responsible for your care regarding your location, general condition, or death.

Marketing. Your information will not be sold to a mailing list company by this office. We may use, or disclose your protected health information for research purposes in limited circumstances.

Food and Drug Administration. We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse effects, product defects, or problems, or deviations, or to conduct post marketing surveillance, as required.

Required by Law. We may use or disclose your protected health information when we are required to do so by law, such as from the US Department of Health and Human Services, or when authorized by workers compensation or similar laws or applicable state laws.

Process and Proceedings. We may disclose your protected health information to law enforcement officials or a court under certain circumstances in response to a court order, warrant, or grand jury subpoena, administrative order, subpoena, discovery request, or other lawful process.

NOTICE OF PRIVACY PRACTICES continued

INDIVIDUAL RIGHTS

You have certain rights under the federal privacy standards. These include:

Access. You have the right to get copies of your protected health information by making a request, in writing, to the contact person at the office address listed. If you request copies, we will charge you twenty-five (25) cents per page and $25 per hour, for staff time, to locate and copy your protected health Information, and postage if you want the copies mailed to you. If you prefer, we will prepare a summary, or an explanation of your protected health information for a flat fee of $35.

Amendments. If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office. To request an amendment, complete and submit a Medical Record Amendment/Correction Form to John C. Hoefs, MD. We may deny your request for an amendment if it is not in writing, or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: (i) we did not create, unless the person or entity that created the information is no longer available to make the amendment, or (ii) is not part of the health information that we keep,; or (iii) you would not be permitted to inspect or copy; or (iv) is not accurate and complete.

Accounting. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and healthcare operations. To obtain this list, you must submit your request, in writing, to Executive Administrator, John C. Hoefs, MD. It must state a time period, which may not be longer than six years and may not include dates prior to April 14, 2003. We will grant this request one time per 12-month period free of charge. Thereafter, the flat fee charge will be $35 per request, inside any 12-month period.

Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit to the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. The agreement must be signed by an authorized executive administrator of John C. Hoefs, MD to be valid.

Communication. You have the right to request that we communicate with you about medical matters in a certain way, or at a certain location. To request confidential communications, you may complete and submit one of the following forms: Request For Restriction On Use, Disclosure of Medical Information. or Confidential Communication. Submissions are to be made in writing to Executive Administrator, John C. Hoefs, MD, 16305 Canyon Avenue, Ste 220 Irvine, CA 92618. You will need to state the reason for your request. All reasonable requests will be accommodated. Your written request must specify exactly how, or where you wish to be contacted.

Copy. You have the right to receive one paper copy of this notice. You may ask us to give you a copy of this notice at any time.

John C. Hoefs, MD Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices. As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Complaints. If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to: Executive Administrator, John C. Hoefs, MD, 16305 San Canyon Avenue, Ste 220 Irvine, CA 92618.

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You may also submit a written complaint to the U.S. Department of Health and Human Services and we will provide you with the address to file your complaint upon request.

You will not be penalized or otherwise retaliated against for filing a complaint.

Effective Date. This Notice is effective on or after April 14, 2003.

NOTICE OF PRIVACY PRACTICES continued

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PACTICES: I acknowledge that I have been provided a copy of the Notice Of Privacy Practices and that I have read (or had the opportunity to read it if I so chose) and understood the notice. I understand that a signed copy of this signature page will be placed in my chart to reflect that I have received the entire notice.

I give my permission for John C. Hoefs, MD, LLC, or staff, to leave results of my medical test(s), or any pertinent information on my message machine or voice mail.

The following number is to be used: _____

Patient Name: _____ Patient Signature: _____
(please print)

Date: _____

If patient is a minor:

Name of Patient Parent, Guardian or Authorized Representative: _____
(please print)

Signature of Parent, Guardian or Authorized Representative: _____

Date: _____

IN ACCORDANCE WITH HIPAA REGULATIONS, PLEASE LIST THOSE WHO MAY RECEIVE MEDICAL INFORMATION REGARDING YOU AND THEIR RELATIONSHIP.

NAME	RELATIONSHIP
NAME	RELATIONSHIP
NAME	RELATIONSHIP

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ELIGIBILITY GUARANTEE & FINANCIAL POLICY

I, _____ ,hereby certify that I am eligible with the following health insurance company _____ under the subscriber name of _____ through his or her employer _____. I also certify that I have chosen Dr. Hoefs to be my medical provider. I understand that if the above is not true, or I am not eligible under the terms of my Medical and Hospital Subscriber Agreement with my insurance company, I am responsible and liable for any and all charges for services rendered. Also, if the above is not true, I hereby agree to pay in full for all services rendered within thirty (30) days of receiving a statement from the above noted medical group/physician.

_____ _____

Signature of Patient Date Print Name of Patient

_____

Signature of Insurance Group Member Date

FINANCIAL POLICY

In order to keep our costs down and still provide the high quality care our patients expect, this office has adopted the following Financial Policy.

PAYMENT FOR SERVICES: Cash, Check or Money Orders will be accepted for payment of services, deductibles, co-pays and co-insurances. There will be a $25.00 charge for returned checks.

SECONDARY INSURANCES: As a courtesy to our patients, if we are supplied with the proper, accurate up-to-date information, any Secondary Insurance claims will be filed. This is done after the Primary Insurance makes payment.

NON-PAYMENT OF ACCOUNTS: Any insurance balance will be billed to the insurance carrier for three months. Any personal balance including deductibles and missed co-payments will be billed to you. If the insurance carrier does not pay the claim within 90 days, you are responsible for payment in full.

NO-SHOWS: Effective January 1, 2010, the practice will be assessing a $100.00 no show charge to any patient account who does not show up for a scheduled appointment. This $100.00 charge will also be added to your account if you fail to reschedule your appointment at least one (1) week, seven (7) days, prior to the scheduled appointment. This new policy has become necessary due to the limited time allocated to patient office visits in the appointment schedule. I value the time allotted to each and every one of my patients. Therefore, every no show appointment takes away from time that could have been allocated to a patient who is waiting to be seen.

QUESTIONS: If you have questions concerning our payment policy, our fees, or difficulty making payment, please contact our billing office at 909-393-0080

My signature below certifies that I have read and understand the terms of the Financial Policy listed above.

_____ _____

Signature of Patient Date Print Name of Patient

_____

Witness Date