Jorge E. Rodriguez MD Inc.

WELCOME!

Our goal at Jorge E. Rodriguez M.D. Inc. is to provide you with the highest quality health care in a professional, caring environment. I, and my staff of highly trained professionals, are here to ensure of that.

The first thing needed is for you to completely fill out the following forms.

A valid credit card is required in order to secure your initial appointment. The credit card information will be taken at the time of the appointment is made. This card is only used in the event of any no show or late cancellation of appointment within 24 hours of scheduled appointment(s).

Enclosed you fill find:

A. **Registration Agreement** – must be signed and dated. **This form needs be sent ahead of initial appointment via fax (323) 934-3691 or email (frontdesk@drjorgemd.com) .**
B. **Patient Information Form. -** must be signed and dated. Can be sent ahead via fax, e-mail, or brought with you at the time of your appointment
C. **HIPPA Patient Consent Form** – must be signed and dated. Can be sent ahead via fax, e-mail, or brought with you at the time of your appointment.
D. **Financial Policy Form** – must be signed and dated. Can be sent ahead via fax, e-mail, or brought with you at the time of your appointment.
E. **Electronic Transmission of Protected Health Information Form** - must be signed and dated. Can be sent ahead via fax, e-mail, or brought with you at the time of your appointment.

Wishing you great health,

Jorge E. Rodriguez M.D.

Registration Agreement

CONSENT FOR TREATMENT

I hereby give consent to the performance of medical examinations, diagnostic testing, vaccinations and immunizations against disease, which in the judgment of Jorge E. Rodriguez MD Inc. (or his assisting physicians or medical personnel who are either employed or contracted by Jorge E. Rodriguez MD Inc.) may be considered necessary and advisable now or during the course of your care. The undersigned further agrees that if they decide to leave the practice without the written consent of the physician, they shall be totally liable for the consequences of such a decision.

ASSIGNMENT OF BENEFITS: FINANCIAL AGREEMENT

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Jorge E. Rodriguez MD Inc. and the assisting physicians and staff for services rendered. I understand that I am financially responsible for all charges provided by Jorge E. Rodriguez MD Inc. whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be valid as the original.

OUT OF NETWORK AGREEMENT

If you are not insured with an insurance company that we are contracted with, you can still be our patient, if you so desire. You hereby agree to pay our cash price at the time of service. You hereby agree to all other policies and procedures of Jorge E. Rodriguez M.D. Inc. An invoice ("superbill") will be given to you by us, at the time of service so that you can submit it to your insurance carrier for possible reimbursement. Reimbursement is between you and your carrier. Reimbursement by your carrier should be made to you. You understand that reimbursement by your carrier is not guaranteed. We will not participate in any way in assisting you to obtain payment by your out of network carrier. All labs and other outside services will be referred, when possible to a company that your insurance carrier is contracted with.

LABORATORY CONSENT

To provide you with the effective medical care necessary, certain lab work may be ordered. Lab specimens collected in our office may be sent to an outside laboratory for analysis and will be billed separately by the LAB.
We will attempt to see that the laboratory has your correct insurance information. By signing this consent, you are giving us permission to send your lab work out and you agree to be financially responsible for any charges not covered under your insurance contract.

NO SHOW/LATE CANCELLATION POLICY and FEES:

In order to respect your appointment time, other patient's appointment times and our time, established patients will be charged a $50.00 fee for no shows or for appointments cancelled with less than 24-hour notice, new patients will be charged a $100.00 fee. All patients are required to have a credit card on file. The credit card will not be charged unless the patient does not comply with our no show/cancellation policy. Credit cards that are declined or contested are subject to additional fees and collection charges.

ON TIME ARRIVAL POLICY:

Patients must arrive at least 15 minutes prior the time of the scheduled appointment in order to register and complete any information needed for the appointment. Patients arriving 15 minutes late (after the scheduled appointment time) may be rescheduled and may be subject to No Show/Late Cancellation fees.

Patients understand that urgent and/or complex needs for patients with prior appointments may cause my physician to be late for my appointment.

APPOINTMENT RESCHEDULING:

I understand that situations may arise where one of the doctors may have to leave the office unexpectedly. In such a situation, I understand the Jorge E. Rodriguez MD Inc. may have to reschedule my appointment for a later time or with another doctor.

PRESCRIPTIONS / MEDICATION REFILLS:

Prescriptions will be sent electronically to your pharmacy at the time of your office visit. Please be aware of your medication needs at **EVERY** office visit. Your physician will give you enough routine medication refills to last until your next visit. If you need a refill prior to an office visit, contact your pharmacy and have them fax a request to our office. **Refill request may take 24-48 hours to complete so we cannot guarantee that your request for refill can be completed the same day as the request. Please be aware of your medication needs BEFORE you run out of medication.**

ELECTRONIC HEALTH INFORMATION:

I hereby consent to and authorize the use of encrypted email to communicate with Jorge E. Rodriguez MD Inc. regarding non-urgent health matters. I further consent that Jorge E. Rodriguez MD Inc. is authorized to leave messages on my voicemail with non-confidential information unless otherwise specified in the "Authorization" form.

PATIENT PHOTOGRAPHY:

I agree to possibly have my picture taken at medical check-in for inclusion in my medical record. I understand that my photograph will be used to protect me form identity theft, to ensure patient safety and to further personalize the services I will receive. My picture helps to confirm that all members of Jorge E. Rodriguez MD Inc. care team are accessing the correct medical records.

PET POLICY:

We love pets. HOWEVER, for numerous reasons, they simply do not belong in a medical environment. They may be dangerous to our staff and other patients, may become scared and lose bladder or bowel control, may scare other patients, and/or may contribute to other patients' allergies, illnesses, or anxiety. Also, no matter how clean a pet is, it may bring problematic germs and matter into our medical facility. For everyone's comfort and safety, please leave your pets at home. If you have a non-pet service animal required to assist you in dealing with a disability, e.g., seeing eye dog, please inform us BEFORE your appointment and we will do our best to fully accommodate you. Please note that an "emotional support animal" is generally not considered a service animal under state or federal law.

I certify that I have read and fully understand all of the above.

☐ Accept

_____ _____

(Patient Name) (Patient Signature)

Date: ____ / ____ / ____

PATIENT INFORMATION

Date: _____ ☐ NEW PATIENT ☐ UPDATE

Patient Name: _____

LAST FIRST MI PREFERRED TITLE

Date of Birth: _____ SSN: _____ Sex: ☐ MALE ☐ FEMALE

Address: _____

ADDRESS LINE 1

_____

ADDRESS LINE 2

_____

CITY ST ZIP CODE

E-Mail: _____

PRIMARY: _____
CELL: _____
WORK: _____
OTHER: _____

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

_____ Tel: _____

NAME RELATIONSHIP Tel: _____

RESPONSIBLE PARTY OTHER THAN PATIENT (GUARDIAN/PARENT ONLY)

Name: _____ SSN: _____

Date of Birth: _____

Address: _____

ADDRESS LINE 1

_____

ADDRESS LINE 2

_____

CITY

HOME: _____
CELL: _____
WORK: _____
E-Mail: _____

INSURANCE INFORMATION

Company: _____
Group #: _____
Plan # _____
Enrollment date: _____

TEL: _____
FAX: _____

PHARMACY INFORMATION

Name: _____
Address: _____

_____

_____

CITY ST ZIP CODE

TEL: _____
FAX: _____

REFERRAL INFORMATION

Referring Physician: _____ TEL: _____

Primary physician: _____ TEL: _____

By signing below, I acknowledge that the above information is true to the best of my knowledge.

Signature: _____ Date: _____

CHIEF COMPLAINT

WHAT IS THE PRIMARY REASON FOR YOUR VISIT TODAY?

HISTORY OF PRESENT ILLNESS

WHERE IS THE PROBLEM LOCATED?

HOW SEVERE IS THE PROBLEM ON A SCALE OF 1-10, WITH 10 BEING MOST SEVERE (CIRCLE ONE)? **1 2 3 4 5 6 7 8 9 10**

WHEN DID THE PROBLEM START?

WHAT MAKES THE PROBLEM BETTER OR WORSE?

IS THE PROBLEM CONSTANT OR VARIABLE?

IS THERE OTHER ISSUES ASSOCIATED WITH THE PROBLEM?

MEDICAL HISTORY

DO YOU HAVE ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐ NONE

- ☐ HIV DISEASE
- ☐ ANEMIA
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ ATRIAL FIBRILLATION
- ☐ AUTO IMMUNE DISORDER
- ☐ CANCER
- ☐ CONGESTIVE HEART FAILURE
- ☐ DEPRESSION/ANXIETY
- ☐ DIABETES
- ☐ GERD
- ☐ HEART ATTACK
- ☐ HEPATITIS
- ☐ HYPERTENSION
- ☐ OTHER

ALLERGIES

DO YOU HAVE ANY ALLERGIES? (MEDICATION, FOOD, ETC.) ☐ NONE

SURGICAL HISTORY

HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐ NONE

- ☐ APPENDIX REMOVAL
- ☐ GALLBLADDER REMOVAL
- ☐ ENDOCRINE SURGERY
- ☐ TONSIL SURGERY
- ☐ BACK SURGERY
- ☐ HEART SURGERY
- ☐ RECTAL SURGERY
- ☐ OTHER
- ☐ COLONOSCOPY/ENDOSCOPY
- ☐ HERNIA SURGERY
- ☐ PROSTATE SURGERY

REVIEW OF SYSTEMS

ALL PATIENTS: DO YOU **CURRENTLY** HAVE ANY OF THE FOLLOWING SYMPTOMS? (CHECK ALL THAT APPLY): ☐ NONE

GENERAL/CONSTITUTIONAL:	☐ FEVER	☐ WEIGHT LOSS	☐ CHILLS
EYES:	☐ BLURRY VISION	☐ DOUBLE VISION	☐ CATARACTS
EARS, NOSE, MOUTH, THROAT:	☐ HEARING LOSS	☐ NASAL STUFFINESS	☐ SORE THROAT
CARDIOVASCULAR:	☐ CHEST PAIN	☐ SWOLLEN ANKLES	☐ IRREGULAR HEARTBEAT
RESPIRATORY:	☐ SHORTNESS OF BREATH	☐ WHEEZING	☐ CHRONIC COUGH
GASTROINTESTINAL:	☐ ABDOMINAL PAIN	☐ NAUSEA/VOMITING	☐ CHANGE IN BOWEL HABITS
GENITOURINARY:	☐ INCONTINENCE	☐ PAINFUL URINATION	☐ BLOOD IN URINE
MUSCULOSKELETAL:	☐ CHRONIC BACK PAIN	☐ CHRONIC NECK PAIN	☐ SORE MUSCLES
INTEGUMENTARY/SKIN:	☐ RASH	☐ PERSISTENT ITCHING	☐ SKIN CANCER HISTORY
NEUROLOGIC:	☐ NUMBNESS	☐ TINGLING	☐ DIZZINESS
HEMATOLOGIC/LYMPHATIC:	☐ SWOLLEN GLANDS	☐ ABNORMAL BLEEDING	☐ TRANSFUSION HISTORY

MEDICATIONS

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? (LIST THEM): ☐ NONE

DRUG NAME	DOSAGE	REASON PRESCRIBED

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED/PARTNERED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

CHILDREN? ☐ YES ☐ NO IF YES, HOW MANY?

OCCUPATION: _____

DO YOU SMOKE? ☐ YES ☐ NO IF YES, HOW MANY PACKS PER DAY? _____

IF YES, FOR HOW MANY YEARS? _____

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO IF YES, HOW OFTEN DO YOU DRINK? ☐ DAILY ☐ WEEKLY ☐ SOCIALLY

DO YOU USE ANY ILLICIT SUBSTANCES ☐ YES ☐ NO IF SO, PLEASE LIST: _____

FAMILY HISTORY

☐ HEART DISEASE ☐ DIABETES ☐ STROKE ☐ CANCER

☐ OTHER (LIST): _____

HIPPA Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose Protected Health Information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent form. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy from our office.

You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or health care operations. You have the right to revoke this consent if it is done so in writing, signed by you, and delivered to our office. However, such revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice is providing this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

1. Protected Health Information (PHI) may be disclosed or used for treatment, payment or health care operations.
2. The Practice has the Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
3. The Practice reserves the right to change the Notice of Privacy Practices.
4. The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions.
5. The patient may revoke this consent in writing at any time and all future disclosures will then cease.
6. The Practice may condition the receipt of treatment upon the execution of this consent form.

I certify that I have read and fully understand all of the above.

☐ Accept

_____ _____

(Patient Name) (Patient Signature)

Date: ____/____/____

Financial Policy

PATIENT CONSENT FOR SERVICES: I hereby consent to and authorize the performance of all treatments, surgery and medical services by Jorge E. Rodriguez MD Inc. These may include but are not limited to: emergency treatment or services, laboratory procedures, x-ray examinations, medical or surgical procedures, or anesthesia proved to me under the general and special instructions of my physician or surgeon

FINANCIAL RESPONSIBILITY FOR SERVICES: I hereby authorize my insurance benefits be paid directly to Jorge E. Rodriguez MD Inc or Jorge E. Rodriguez. I understand that I may have financial responsibility for all or a portion of the charges of the professional services rendered and will remit appropriate payment at the time of service, including specifically co-payments and charges for services, which are not covered by my insurance.

CO-PAYMENT / DEDUCTIBLES POLICY: Co-Payments are due at time service is rendered. If I present for my appointment without my co-pay, my appointment may be rescheduled. If an appointment is rescheduled at this time, I may be subject to no show / late cancellation fees. Unmet deductibles may be collected at the time of an office visit and prior to any tests/procedures.

INSURANCE COVERAGE: I acknowledge that it is my responsibility to understand the benefits and limitations on benefits under my insurance or health plan and to contact my insurance carrier/health plan if I have questions.

REFERRALS/AUTHORIZATION: I understand that depending on my insurance I may need a referral from my provider to see a specialist. If so, and my provider decides it is medically necessary, I will allow 7-10 working days for this process. I will be promptly advised of any requests that are determined not to be appropriate and necessary. I understand that if I choose to access specialty services without prior authorization from my provider, or I elect to use a Point of Service option or fail to notify the above providers if my insurance plan requires specific outside vendors such as laboratories to perform referred services, I may be financially responsible for the services rendered and insurance may not cover the relevant services.

ANCILLARY SERVICES: I understand that depending on my insurance, I may receive a separate bill for laboratory, x-ray, anesthesia or other ancillary services.

RELEASE OF INFORMATION: I authorize the release of my medical records or other information necessary to provide health care, to process my medical claims and for other purposed relating to health care operations.

FEES FOR PATIENT'S HEALTH INFORMATION: I hereby understand that I may be charged a cost-based fee when requesting copies of my health information, including the cost of copying (supplies and labor), postage (if information is to be mailed), and preparation for any summary or explanation, if agreed to in advance: $25.00 to pull chart and if over 10 pages, $0.25/page additional.

FEE FOR FORMS: I understand that if I request to have any forms completed by my physician that are not directly related to patient care, I will be required to pay a fee of $35.00 in advance. Examples included but are not limited to: Jury duty excuses, Federal Family Leave Act application, accident reports and school or camp forms. There may be other forms with the associated fees. Forms may take up to seven (7) business days to complete. **Payment of fee does not guarantee approval of application/excuse.**

PRE-CERTIFICATION: Your insurance carrier may require that procedures, injections and surgeries require pre-authorization or pre-certification. We will assist you with this process by contacting your insurance company on your behalf. Please check with your scheduler to be sure that the pre-certification was obtained, so that you will avoid incurring additional charges. We will verify your benefits and you will be responsible for an co-pays, deductibles and co-insurance. These will be collected prior to your surgery or procedure. Pre-certification does not guarantee insurance payment. Allow 5-7 business days for pre-certification.

PRIOR AUTHORIZATIONS: Your insurance carrier may require a "Prior Authorization" for certain types of medications that might not be listed on your medication formulary. This prior authorization will require significant amount of time on behalf of the medical assistant. There will be a fee of $25.00 paid in advance before any authorization is started. Please allow 5-7 business days for prior authorizations to be filed. **Payment of fee does not guarantee authorization by your insurance company.**

TELEPHONE CONSULTATION / REVIEW FEE: I understand that providing telephone service not only requires a significant amount of time for a physician and staff, but that it may involve a medical decision. This places the physician in as much liability as with a personal appointment. **That is why telephone consultations and/or telephone lab reviews are highly discouraged.** Nothing takes the place of the personal doctor patient interaction. I also understand insurance companies sometimes DO NOT reimburse for telephone services. We will attempt to bill your insurance company. If the telephone consultation is not a covered service for you, based on the issue and complexity of the phone consultation a fee starting at $100.00 will be charged for this service. I agree to pay this fee.

I certify that I have read and fully understand all of the above.

☐ Accept

_____ _____

(Patient Name) (Patient Signature)

Date: ____ / ____ / ____

NO SHOW / LATE CANCELLATION FEE AUTHORIZATION

NEW PATIENT: $100.00
ESTABLISHED PATIENTS – 15 - 30 MINUTE APPOINTMENT: $50.00
ESTABLISHED PATIENTS – 45 MINUTE APPOINTMENT: $100.00

Patient: _____ Account #: _____

Address: _____

City: _____ State: _____

Zip Code: _____ Telephone: _____

CREDIT CARD:

☐ AMEX ☐ VISA ☐ MASTERCARD

Cardholder's Name: _____

Card #: _____

Expiration Date: _____ CCV: _____

Billing Zip Code: _____

I certify that I have read and fully understand the No Show / Late Cancellation Policy and fees located in the Registration Agreement section.

☐ Accept

_____ _____

(Patient Name) (Patient Signature)

Date: ____ / ____ / ____

Authorization of Electronic Transmission of Protected Health Information

Protected health information (PHI) is any health information in the medical record or designated record set that can be used to identify an individual and that was created, used or disclosed in the course of providing a health care service such as diagnosis or treatment. For other than test results, a valid HIPPA compliant release must be completed. You may further authorize us to release your PHI to answering devices, faxes or electronic mail. To ensure your privacy, we will not leave messages containing PHI on answering devices without your permission. You may also authorize us to provide your confidential PHI to another person or persons. Under California law, test results related to HIV, Hepatitis, substance abuse or malignancy/cancer may not be transmitted to patients via electronic means (voicemail, fax, email, Internet).

By signing this agreement, I authorize Jorge E. Rodriguez MD Inc., physicians and/or staff to contact me as indicated in the following contact questions.

Preferred Contact:	Detailed Message	MD's name and number only	Do not leave message
Primary/Mobile Phone	☐	☐	☐
Business Phone	☐	☐	☐
Email	☐	☐	☐

Does the Patient Authorize Contact by Fax number YES ☐ NO ☐

Does the patient Authorize Contact and/or
Message on a telephone-answering device? YES ☐ NO ☐

Does the patient authorize contact by email? YES ☐ NO ☐

I certify that I have read and fully understand all of the above.

_____ _____
(Patient Name) (Patient Signature)

Date: ____ / ____ / ____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

To: _____

Address: _____

_____

Telephone: _____

Fax: _____

Patient name: _____

Date of Birth: _____

Release to be released to:

Jorge E. Rodriguez, MD
5901 W. Olympic Blvd., Suite 303
Los Angeles, CA. 90036
Tel: (323) 934-3690
Fax: (323) 934-3691

By signing and dating below, I hereby authorize release of my protected health information (PHI) or a summary or narrative of my PHI to the physician/person/facility/entity listed above.

Patient Signature: _____ **Date:** _____

If patient unable to sign:

Name of Guardian/Representative: _____

Signature of Guardian/Representative: _____

Relationship: _____ **Date:** _____