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.

In order to secure your initial appointment, you must get back the **New Patient Appointment Agreement Form** to us within 2 business days of making your initial appointment. (Fax: 323-934-3691 or e-mail: frontdesk@drjorgemd.com) We realize that your time, and every other patient's time, is valuable.

Enclosed you fill find:

A. **Registration Agreement** – *must be signed, dated and returned to us within 2 business days of making your appointment, in order to hold your appointment.*

Other forms in this packet:

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. A 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, you will be charged $50 for no shows or for appointments cancelled with less than 24-hour notice. Late cancellation/no show fees also apply to new patients. The fee for new patients is $100. All new 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. If you do not leave a credit card on file, then your signature below signifies that you agree to have us bill you for no show and late cancellations and that you understand that none payment of said charges will necessitate we use collection agencies for the collection of said fees.

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.

My signature acknowledges my agreement to the CONSENT FOR TREATMENT, ASSIGNMENT OF BENEFITS: FINANCIAL AGREEMENT, OUT OF NETWORK AGREEMENT (If Applicable), LABORATORY CONSENT and NO SHOW/ CANCELLATION POLICY and FEES.

[] Yes, I authorize by signing below, that I understand all the policies of Dr. Jorge E. Rodriguez office. I do not call the office 24 hours prior to my scheduled appointment, and I do not Show up to the scheduled appointment the credit card given below will be charged. This card will NOT be used for any other purposes.

Credit Card Number	Expiration Date	Security Code

Patient Name	Patient Signature	Date

[] No, I refuse to provide a credit card now, but I do understand if I fail to miss any appointment(s) or do not cancel within 24 hours from the scheduled appointment and do not show up, I will be billed for any fee(s) and failure to pay will result in further collection activity.

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:

HOME:
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:

NAME | RELATIONSHIP

Tel:
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:

5901 W Olympic Blvd Suite 303 Los Angeles, CA 90036
Phone: 323-934-3690 Fax: 323-934-3691

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

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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 Accept

____ I Decline

Patient Signature:

_____

Patient Name:

_____

Date: ___/___/___

Jorge E. Rodriguez M.D. Inc.

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 POLICY: If applicable I will be required to pay a co-payment If I do not pay my co-payment, I understand that future visits may be cancelled.
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: $20.00 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. Examples included but are not limited to: Jury duty excuses, Family Leave Act application, accident reports and school or camp forms. There may be other forms with the associated fees. $50.00.

ON TIME ARRIVAL POLICY: I understand that I must arrive at least 15 minutes before the time of my appointment in order to register and complete information prior to the time my physician is scheduled to see me. If I arrive 15 minutes late for my scheduled appointment, I understand that it might be necessary to reschedule my appointment.
I understand that urgent or complex needs for patients with prior appointments may cause my physician to be late for my appointments.

MEDICATION REFILIS: I understand that refills may take 24-48 hours to complete and that the most efficient way to get a refill is to contact my pharmacy directly. Refills will not be done after the close of office hours nor during weekends or holidays. DO NOT contact the office for refills. Contact your pharmacy. They will contact the office. In order to ensure timely refills, I agree to notify my physician's office regarding my preferred pharmacy.

ELECTRONIC HEALTH INFORMATION: 1 hereby consent to and authorize the use of encrypted email to communication 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.
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 that Jorge E. Rodriguez MD Inc. may have to reschedule my appointment for a later time or with another doctor.
PATIENT PHOTOGRAPH: I understand that Jorge E. Rodriguez MD Inc. is committed to the protection of my identity and medical information. 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 from 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.

TELEPHONE SERVICE 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 place, the physician in as much liability as with a personal appointment That is why telephone consultations, 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, however, his is not a covered service for you, based on the issue and the amount of time spent I may be charged up to $100.00 fee for this telephone service. I agree to pay this fee.

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

____ ACCEPT

____DECLINE

PATIENT SIGNATURE:

_____

PATIENT NAME:

_____

DATE: ___/___/___

Jorge E. Rodriguez MD Inc.

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
Cell Phone	___	___	___
Home Phone	___	___	___
Business Phone	___	___	___

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 ___

Patient Name: _____

Patient Signature: _____

Date: _____/_____/_____

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

RELEASE OF MEDICAL RECORDS

To: _____

Address: _____

Tel: _____ Fax: _____

Regarding: _____ Date of Birth: _____
(Patient name)

Records to be release to:
5901 W. Olympic Blvd., Suite#303
Los Angeles, CA 90036
Tel: 323-934-3690 Fax: 323-934-3691

The purpose/reason for this release of information is as follows:

_____

By signing and dating this release of information, I authorize you to release confidential health information about me, by releasing a copy of my medical records or a summary or narrative of protected health information, to the physician/person/facility/entity listed above.

_____ _____
(Patient Signature) (Date)

If patient unable to sign:

_____ _____
(Name of Guardian/Patient representative) (Relationship)

_____ _____
(Signature of Guardian/Patient representative) (Date)