



PATIENT INTAKE

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Social Security: _____ - _____ - _____ Gender: M F
Marital Status: S M W D DP Date of Birth: _____
Phone: Home (____) _____ - _____ Work (____) _____ - _____
Cell: (____) _____ - _____ Email: _____
Referred by: _____
Employer: _____ Occupation: _____

SPOUSE OR PARENT/GUARDIAN

Name: _____ Relationship to Patient: _____
Phone: () _____ - _____

EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____
Phone: () _____ - _____
Signature: _____ Date: _____

___ Yes, would like to receive special announcements from www.executiveER.com

___ Yes, I would like to receive my appointment reminder via text message.

___ AT&T, Verizon, Sprint, T-Mobile, Other _____

NEW PATIENT QUESTIONNAIRE

Name: _____

Today's date: _____

To help us get the most out of today's visit, please answer the following questions:

1. **What is your main purpose in coming to our office today?** (If you have a new complaint, indicate how long it has been present, what it feels like, what makes it better or worse, and what you are concerned the problem might be.)

2. **Are you experiencing any of the following symptoms in relation to your main concern?**

(Answer "yes" by circling the appropriate symptom.)

Constitutional symptoms: fever, weight loss, extreme fatigue

Eyes: double vision, sudden loss of vision, blurred vision

Ears, nose, mouth and throat: sore throat, runny nose, ear pain

Cardiovascular: chest pain, palpitation

Respiratory: cough, wheezing, shortness of breath

Gastrointestinal: nausea, vomiting, abdominal pain, constipation, diarrhea, blood in stools

Genitourinary: irregular menses, vaginal bleeding after menopause, frequent/painful urination, bloody urine, impotence

Skin: rash, changing mole

Neurological: headache, persistent weakness or numbness on one side of the body, falling

Musculoskeletal: joint pain, muscle weakness, stiffness, restricted movement

Psychiatric: depression, anxiety, suicidal thoughts

Endocrine: excessive thirst, cold or heat intolerance, breast mass

Hematologic: unusual bruising or bleeding, enlarged lymph nodes

Allergic: hay fever

3. **Do you have any other concerns?** Yes (list below) No

4. **Do you have any drug allergies?** Yes (list below) No

5. **List any medications/supplement you are currently taking.**

6. **Do you (currently) or have you had (previously) any major medical problems?** Yes (list below) No

7. **Have you had any surgeries?** Yes (list below) No

8. **Does anyone in your family have a medical illness such as DM, HTN, high cholesterol, cancer or other?** Yes (list below) No

9. **What do you do for exercise?** _____ **How long?** _____ **How often?** _____

Note: Brisk walking for 30 minutes most days is associated with a 30% reduction in the risk of heart attacks.

10. **How much tobacco do you smoke/chew per day?** _____ **Note:** It is recommended that you stop using tobacco.

11. **How much alcohol do you consume per week?** _____

12. **How much caffeine do you consume per day?** (i.e., coffee, tea, chocolate, soda) _____

13. **What method of birth control do you use?** Not Applicable The pill Vasectomy Tubal ligation

Other (specify): _____

Patient Signature

Office Policies

Dear Patient,

Thank you for choosing the Executive ER for your health care needs. Our office is truly a multi-disciplinary, multi-specialty clinic. We offer Urgent/Emergent Medical Care, Chiropractic Care, Therapeutic Exercise, Massage Therapy, and Medically Supervised Weight Loss Programs. Our philosophy is simple, we treat the whole person not just the symptom. Our goal is to correct the cause, not cover up the complaint.

All patients receive a medical evaluation after which our medical staff decides what course of treatment, if any, will benefit you. All treatments are provided under the direction and supervision of our qualified board certified medical doctors.

Financial Polices

Because we are a California Medical Corporation we follow both California State Insurance Laws as well as Federal Medicare Guidelines. All patients are responsible for their deductibles and co-payments. For the aforementioned reasons insurances billings, receipts and statements for every procedure or treatment are billed under our group name Executive ER (Beverly Hills Executive Medical Group) and the supervising medical director, Cherlin Johnson, M.D. We have only one set of fees, which are set by the State of California Relative Value System.

Payment Policies

All visits must be **paid in full** at the time of service **unless prior** arrangements have been made and approved by our office manager. The only exceptions to this policy are **1. Medicare** patients by law have a 24-hour payment period and **2. Approved Workers Compensation** patients are not required by law to pay for their own treatment, unless it is self-procured.

We gladly accept cash, checks, Visa, MasterCard, Amex and most insurance policies.

Appointment Policies

All visits are on an appointment basis. This means we have specifically reserved a time slot for you. If you need to change or cancel an appointment you must give 24 hours notice or you will be charged a \$25 - \$75 cancellation fee. Emergency patients will be seen on first come first served basis or between regularly scheduled patients.

I have read and understand the office policies.

Name _____

Dated _____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow the Executive ER (Beverly Hills Executive Medical Group, Inc.) to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient

Date

Signature of Patient

PATIENT CONSENT & AUTHORIZATION

CONSENT FOR TREATMENT: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician(s) and it is the responsibility of the staff to carry out the instructions of the physicians.

ASSIGNMENT OF BENEFITS: I hereby assign payment directly to the Executive ER (Beverly Hills Executive Medical Group) for medical benefits applicable and otherwise payable to me, but not to exceed the physician's regular charges. I specifically direct any second or third party to accept this assignment and pay the physician directly. I understand that I am financially responsible for charges that the insurance carrier declines to pay. In the case that a check is made to the patient or this office and the patient, for services rendered by this office, this document serves as a power of attorney for endorsement on the patient's behalf.

LIEN: In the event that a lien is necessary to protect and ensure payment to the Executive ER, this document serves as notice of lien on any claim I may have and serves as a power of attorney for signature on my behalf on such lien form should it be needed.

RELEASE OF INFORMATION: I authorize the release of information contained in my chart to relevant insurance companies, third parties, attorneys and employers as may be needed to process and manage my case and claims.

REQUEST FOR INFORMATION: I authorize any custodian of records to release medical records and diagnostic studies (including X-Rays) to the Executive ER for the purposes of case management.

HMO DISCLAIMER: I certify that I am not presently enrolled in any health Maintenance Organization (HMO). Subsequent rejection of a claim as a result of my enrollment in an HMO will constitute responsibility for payment of claim on my part.

MINOR'S RELEASE: If the patient is a minor, my signature as parent/guardian authorizes any needed treatment and diagnostic for the minor.

PREGNANCY: There is no reason to suspect that I might be pregnant at this time. If there is a possibility that I might be pregnant, I will advise the doctor prior to any X-Ray or onset of care.

Patient's Name

Date

Patient, Patient's Parent/Guardian Signature

Acct. #