Registration Form

Basic Information

Name:____ Date of Birth: ___________________
Last First Middle Initial Month Date Year

Street address: ___________________________________

City: ____________________________ State: ______________ Zip code: ____________

Home phone: ______________________ Mobile phone: ________________________

Email:____

I certify that I, and/or my dependent(s), have insurance coverage with:

_____________________________ ____________________________________

Name of insurance company(ies) **Policy/ID** Number

I assign directly to Dr. Presser Belkin all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment services and determining insurance benefits or benefits payable for related services including telehealth and/or virtual consultations.

____ _________________________

Signature of Patient, Parent, Guardian, or Personal Representative Date

____ _________________________

Please print name of Parent, Guardian, or Personal Representative Relationship to Patient

Environmental Exposure Review

Timing, Season of symptoms: ____

Is there a geographic variation in your symptoms?:____

Do you have symptoms with inhalants? ☐Yes ☐No

Are your symptoms worse when dust is present? ☐Yes ☐No

Is your bedroom carpeted? ☐Yes ☐No

Do you have drapes or window coverings in your bedroom? ☐Yes ☐No

Do you have a feather bed, pillow, or down comforter? ☐Yes ☐No

Do you have forced air heating? ☐Yes ☐No

Do you have forced air conditioning? ☐Yes ☐No

Are you exposed to mold at home or at work? ☐Yes ☐No ☐ Home ☐ Work

Do you presently have (are exposed to) a cat? ☐Yes ☐No

If so what are your symptoms, if any, with cat exposure:____

Do you presently have (are exposed to) a dog? ☐Yes ☐No

If so what are your symptoms, if any, with dog exposure:____

What are, if any, your symptoms with grass exposure?

____

Do you have any symptom changes with weather patterns like rain, wind, cold? ☐Yes ☐No

If yes, please explain:____

Review of symptoms (please check all that apply):

Constitutional

- ☐ Fevers
- ☐ Chills
- ☐ Weight loss/weight gain
- ☐ Night sweats

Skin

- ☐ Rashes
- ☐ Lesions
- ☐ Ulcers
- ☐ Jaundice/discoloration

Eyes

- ☐ Dry eyes
- ☐ Double vision
- ☐ Visual loss

Head, Ears, Nose, Mouth, Throat

- ☐ Headaches
- ☐ Dizziness
- ☐ Lightheadedness or vertigo
- ☐ Sore throat
- ☐ Thrush
- ☐ Hoarseness of voice
- ☐ Nasal discharge
- ☐ Nasal polyps
- ☐ Nasal obstruction
- ☐ Nasal epitasis
- ☐ Sinus congestion

Respiration

- ☐ Shortness of breath
- ☐ Asthma
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Valley fever
- ☐ Cough
- ☐ COPD
- ☐ Coughing of blood
- ☐ Pneumonia
- ☐ Wheezing
- ☐ Tuberculosis
- ☐ Sputum production
- ☐ Snoring

Lymphatics

- ☐ Lymph node enlargement

Cardiovascular

- ☐ Palpitations
- ☐ Irregular heart beat
- ☐ Chest pain
- ☐ Hypertension
- ☐ Heart attack

Gastrointestinal

- ☐ Heart burn (GERD)
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Blood in stool

Musculoskeletal

- ☐ Color changes to fingers
- ☐ Muscle pains
- ☐ Joint pains
- ☐ Leg swelling

Genitourinary

- ☐ Painful urination
- ☐ Blood in urine
- ☐ Genital discharge

Neurologic and Psychiatric

- ☐ Difficulty walking
- ☐ Numbness
- ☐ Difficulty speaking
- ☐ New onset seizures
- ☐ Anxiety
- ☐ Depression

Notice of Privacy Practices

Acknowledgment of Receipt

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices of* ***Liza Presser Belkin MD, Inc*** and/or acknowledge that the *Notice of Privacy Practices of Liza Presser Belkin MD, Inc* is available upon your request. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read in full.

Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our organization at **805-569-3377** or finding it online at **http://drpresserbelkin.com/**

I acknowledge receipt of the *Notice of Privacy Practices* of ***Liza Presser Belkin MD, Inc.***

Signature:______________________________________ **Date:**_____________________

Patient, Parent, Guardian, or Personal Representative

Patient Care Financial Agreement

The purpose of this agreement is to give you a clear understanding of our policy concerning payment for appointments that are not cancelled within 24 hours in advance and for patients who have "no showed" for their appointment.

When an appointment is made for a skin test, follow-up, or any other procedure at Dr. Liza Presser Belkin's office, our professional time, treatment rooms, and equipment are solely dedicated for your use and treatment. This allows you, our valued patient, to receive the care and expertise you deserve in an environment designed especially for your needs. Last minute cancellations and "no-shows" make it difficult and even impossible to make the best use of Dr. Presser Belkin's time.

We appreciate the time we are able to spend with you. We diligently strive to be prepared and on time for your appointment so that you can receive the maximum benefit during your time at our office.

As such, we charge a $150 fee if we do not get cancellation notice within 24 hours of your appointed time.

To avoid the $150 penalty, we ask that you please notify us with at least 24 hour advanced notice if you are unable to make your scheduled appointment.

We thank you for your time and cooperation.

I hereby authorize this office to charge my account a fee of $150.00 should I fail to notify the office at least 24 hours in advance in the event that I am unable to attend my scheduled appointment.

____ ________________________

Signature of Patient, Parent, Guardian, or Personal Representative — Date

____

Name of Patient, Parent, Guardian, or Personal Representative

Arbitration Agreement

Article 1: **Agreement to Arbitrate**: it is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must Be Arbitrated**: it is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term “patient” herein shall mean both the mother and the mother’s expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician’s partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law**: a demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party’s pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party’s own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure Section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions**: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5**: Revocation**: This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect**: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services ____

Patient’s or Patient Representative’s Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By:____ _______________

Patient’s or Patient Representative’s Signature **Date**

By:____

Print Patient’s Name

____

If Representative, Print Name and Relationship to Patient

By:____ _______________

Physician or Authorized Representative Date

LIZA PRESSER BELKIN, MD INC.

PATIENT REGISTRATION

Please PRINT

NAME: ____

LAST FIRST MIDDLE INITIAL

BILLING ADDRESS: ____

CITY: ______________________________________ STATE: ________ ZIP CODE: __________________

STREET ADDRESS: ____

HOME PHONE: (______) ______________________ **GENDER**: (Circle one) MALE FEMALE

CELL PHONE: (______) ______________________ **BIRTHDATE**: _______ / _______ / __________

WORK PHONE: (______) ______________________ **SOCIAL SECURITY #**: ________-_______-__________

EMAIL ADDRESS: ____

EMPLOYER: ____________________________ **Preferred Pharmacy:** __________________________

MARITAL STATUS:(Circle one) S M W D **RACE**:(Circle) White Asian Black or African American American Indian Native Hawaiian Hispanic

SPOUSE'S NAME: ________________________ **SPOUSE'S PHONE**: (______) ______________________

EMERGENCY CONTACT: __________________________ **PHONE**: (______) ______________________

Different than your phone #

Relationship to patient: __________________________

RESPONSIBLE PARTY: (Circle one) SELF PARENT/GUARDIAN: ________________ OTHER: ________________

INSURANCE INFORMATION:

PLEASE PRESENT YOUR INSURANCE CARD(S) TO THE RECEPTIONIST

Financial Policy:

I hereby authorize treatment by Presser Belkin and understand that I am financially responsible for all fees and charges for such treatment whether or not they are covered by my insurance policy. I understand Dr. Presser Belkin is contracted with some, not all, insurance plans and it is my responsibility to be aware of the terms and limitations of my insurance coverage. If my insurance policy is through an HMO I understand that it is my responsibility to ensure that authorization has been obtained from my primary care physician **prior** to receiving services from Dr. Presser Belkin. If such authorization has not been given, I understand that I will be financially responsible for all fees and charges.

I understand that during the course of my office visit with Dr. Presser Belkin it may be necessary for her to perform additional diagnostic or therapeutic services at her discretion. I authorize any such diagnostic or therapeutic services and understand that charges for these services will be in addition to the regular office charges.

I authorize Dr. Presser Belkin to furnish any medical information necessary to prove my claim to my insurance carrier and to other physicians, hospitals, and health care facilities and hereby irrevocably assign to the providing doctor payment for all medical services and unpaid balances. I authorize copies of this authorization to be used in place of the original. If my account is referred to an attorney or collection agency, I agree to pay reasonable fees and collection expenses. This authorization will remain in effect until revoked by me in writing.

PATIENT SIGNATURE: ________________________________ DATE: ____________________

AUTHORIZED REPRESENTATIVE SIGNATURE: ______________________ Reason: ____________________

TELEHEALTH INFORMED CONSENT

Telehealth, including virtual visits (two way interactive audio/video), telephone (audio only), electronic communications (HIPAA compliant patient portal/secure messaging) are all ways to visit with your healthcare providers without coming into the office. These visits are held by computer, tablet, or cell phone through Elation Passport, our office's Electronic Medical Records portal. All telehealth visits as above are billable services.

This form gives permission for telehealth communication between **Liza Presser Belkin, MD** and

__________________________________ ______________________

Patient name Patient DOB

Patients Initials:

____ I understand that telehealth involves sharing my health information electronically. I will tell my healthcare provider if there is any information that I do not want to talk about in a telehealth visit.

____ I understand that I may stop the telehealth visit at any time. If I decide to stop, I will still be able to receive care at this office.

____ I understand that I may have to check with my insurance plan to see if telehealth visits are covered.

____ I understand that telehealth visits carry some level of risk. These risks include but are not limited to:

- My computer, tablet, or phone may not be private and secure. Especially if other people use it. It is my responsibility to make sure my internet system is private and secure and to make sure I am in a private place during my visit.
- Technical problems may occur and can interrupt or stop my visit before it is done.
- My healthcare provider cannot examine me as closely during a telehealth visit, and this may make it harder to determine what is wrong with me.

____ I agree that information shared during my telehealth visit **will** or **will not** be recorded.

____ I understand that I will be asked to confirm my identity and current location to the healthcare provider seeing me.

____ I also have the right to confirm the identity and credentials of the healthcare provider who is seeing me.

_____ I agree to follow my healthcare provider's recommendations – including lab tests and x-rays, sending me to a specialist or asking me to come to the office or go to an emergency department for an in person visit.

PATIENT SIGNATURE: ______________________________________ DATE: ________________________

AUTHORIZED REPRESENTATIVE SIGNATURE:_________________________Reason:_______________________

Chronic Care Management (CCM) and Principal Care Management (PCM) Informed Consent

Informed Consent

You are eligible for a new Medicare program that enables us to provide you with around-the clock service to oversee your chronic conditions and improve your overall wellness. Chronic conditions are ongoing medical problems like asthma, allergic rhinitis, atopic dermatitis, immunodeficiency, cystic fibrosis, and many others. These conditions must be managed effectively in partnership between the healthcare team and patient to maintain the best possible overall health and wellness. CCM Services are available to you because you have been diagnosed with two (2) or more chronic conditions which are expected to last at least twelve (12) months and which place you at significant risk of further decline. PCM Services are available to you because you have been diagnosed with at least one chronic condition which is expected to last at least twelve (12) months and which place you at significant risk of further decline

What are the benefits of signing up for Chronic/Principal Care Management Services?

• Coordinate visits with your doctors, facilities, labs, radiology, or others
• Provide access to around-the-clock (24/7) services from your care team
• Assist with management of medications
• Provide a personalized and comprehensive care plan management
• Assist with scheduling preventive care services, many of which are covered by Medicare

NOTE: You must sign an agreement or provide verbal consent to receive this type of chronic care management services.

What do you need to know before signing up?

Medicare will allow us to bill for these services during any month that we have provided at least 20 minutes of non-face-to-face chronic care management services. Medicare will reimburse us approximately 80% and requires you to pay approximately 20% (your Medicare coinsurance amount, may be covered by your secondary insurance) each month that you receive at least 20 minutes of chronic care management. Our office will have the record of when and how the 20 minutes were spent and you will have 24/7 access to your electronic medical record if you ever have questions. Our practice is compliant with HIPAA and all laws related to the privacy and security of Protected Health Information (PHI). As a part of this program, your PHI may be shared between caregivers directly involved with your health.

You have a right to:
Discontinue this service at any time for any reason. Because your signature is required to end your chronic care management services, please ask any of our staff members for the CCM/PCM termination form. The provider will continue providing CCM/PCM services until the end of the month and may bill Medicare for those services. After the end of the month, the provider will discontinue CCM/PCM services and no longer bill for those services to Medicare. NOTE: Only one physician can bill for this service for you. Please let your physician or our staff know if you have entered into a similar agreement with another physician/ practice.

Beneficiary Acknowledgment and Authorization. By signing this Agreement, you agree to the following:

● You consent to the Provider providing CCM/PCM Services to you. You authorize electronic communication of your medical information with other treating providers as part of coordination of your care.
● You acknowledge that only one practitioner can furnish CCM/PCM Services to you during a calendar month.
● You understand that cost-sharing will apply to CCM/PCM Services, so you may be billed for a portion of CCM/PCM Services even though CCM/PCM Services will not involve a face-to-face meeting with the Provider.

I agree to participate in the Chronic Care Management or Principal Care Management program. ❑ Yes ❑ No

PATIENT SIGNATURE: ____ DATE: _________________________

AUTHORIZED REPRESENTATIVE SIGNATURE:___________________________Reason:_________________________