LEW MEDICAL
DIPLOMATS OF THE AMERICAN BOARD OF FAMILY PRACTICE
**Edmund H. Lew, MD | Ryan Lew, FNP-C | Katherine Hammond, FNP-C**
1505 Wilson Terrace Suite 250, Glendale, CA 91206
TEL: (818) 246-7115 | FAX: (877) 366-1148

## PATIENT INFORMATION

**NAME:** First: _____ ast: _____ Middle Initial: ____
L

Date of Birth: ____ /____ /_____ SSN: _____ Sex: Male ____ Female _____

Marital Status: _____ (If married) Spouse name: _____

Race: _____ Ethnicity: _____ Language of choice: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Numbers: Home: _____ Cell: _____ Work: _____

Fax: _____ Email: _____

Preferred Method of Contact: [ ] Home [ ] Cell [ ] Email

Employment Status: [ ] Full-time [ ] Part-time [ ] Not Employed [ ] Self Employed [ ] Retired [ ] Active Military

Employer: _____ Occupation: _____

Insurance Carrier: _____ Are you the primary card holder [ ] Yes [ ] No

Name of Primary Card holder: _____ Relationship to Patient: _____

Financial Responsibility Party: [ ] Self [ ] Guarantor

Guarantor Name: _____ Relationship to Patient: _____

Address: (if different to patient) _____ City: _____State: ____ Zip: _____

Guarantor Date of Birth: _____ /_____ /_____ Guarantor Tel: _____

**Emergency Contact:** [ ] Same as Guarantor [ ] Other

Name: _____ Relationship to Patient: _____

Address: _____ City: _____State: ____Zip: _____ Tel: _____

Local Pharmacy: _____ Location: _____

Tel: _____ Fax: _____

**Signature of Patient or Responsible Party Granting Permission to Lew Medical to Treat, Diagnose and Prescribe:**

**PATIENT SIGNATURE: _____ Date: _____/_____/_____**

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# AUTHORIZATION TO RELEASE & EXCHANGE MEDICAL INFORMATION

THIS RELEASE AUTHORIZES LEW MEDICAL TO RELEASE AND EXCHANGE ALL OF MY MEDICAL INFORMATION WITH THE FOLLOWING DESIGNATED INDIVIDUALS: *(Spouse, Parent(s), Child(ren), Legal Guardian, Caregiver, Power of Attorney etc)*

1. NAME: _____ RELATIONSHIP: _____

   PHONE NUMBER: _____
2. NAME: _____ RELATIONSHIP: _____

   PHONE NUMBER: _____
3. NAME: _____ RELATIONSHIP: _____

   PHONE NUMBER: _____

*TO INCLUDE THE FOLLOWING:*

- Appointments
- Diagnosis, Assessment and Planning of Care
- Test Results
- Progress Information
- Insurance and Billing Inquiries
- Mutual Exchange of Information

PATIENT SIGNATURE: _____ DATE: _____

PATIENT NAME (PRINTED): _____ DATE OF BIRTH: _____

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## PATIENT PAYMENT POLICY

- Payment in full for all examination fees is required at the time the service is rendered.

- Patients without insurance, insurance cards, incomplete insurance information, or authorizations will be required to pay in full at the time of service.

- We will bill your insurance company for the services rendered by our providers. Please be aware that your insurance may not cover any or part of the fees. We will bill your insurance based on the diagnosis determined by our providers. We cannot be responsible for the coverage provided by your insurance.

- We accept cash or card payments. We accept Visa, Mastercard, and American Express.

- Co-pay is due at the time of service. If you have a deductible, we collect $50.00 until your deductible is met.

- A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

- If your account becomes delinquent (past due), we may take the following actions: (1) refer your account to a collection agency, (2) file a lawsuit to recover the amount owed. If your account is referred to a collection agency, you agree to pay a collection fee and interest at an annual rate of 10% on the unpaid balance, beginning 30 days after the date of service. If legal action is required to collect the amount owed, you agree to pay all reasonable attorney's fees and court costs incurred in the collection process, in addition to the outstanding balance, collection fees, and interest.

I have read, understand, and agree to abide by the above payment policy. I understand that all charges not covered by my insurance company, all copayments, and deductibles are my responsibility.

SIGNATURE: _____

PRINTED NAME: _____ DATE: _____

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# HIPAA COMPLIANCE

PLEASE READ CAREFULLY:

I. Regardless of your insurance coverage or third-party involvement, it is your responsibility to remit a full payment for the service(s) rendered. You will receive a statement of account each month regardless of your insurance coverage. It is your responsibility to know and understand your insurance policy and coverage for service(s) rendered.

II. I hereby authorize the release of my medical records to insurance(s) and/or third-party payer(s) in regards to payments, eligibility, or coverage of services rendered.

III. I hereby agree to have any issue to medical malpractice decided by neutral arbitration; and by signing my name, I agree to give up my right to a jury or court trial.

IV. I have been given the opportunity to review this office's manual of privacy practices. V. Your copay is due at the time the service is rendered.

V. We require 24-hour notice for cancellation of appointments. Failure to notify us that you will not be keeping your appointment may result in a fine.

PATIENT NAME: _____

SIGNATURE OF PATIENT / RESPONSIBLE PARTY: _____

DATE: _____

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# MEDICAL HISTORY

PATIENT NAME: _____ DATE OF BIRTH: _____

PREVIOUS PRIMARY CARE PHYSICIAN: _____

SPECIALISTS: _____

*Please describe your current medical condition:*

| ***Have you ever been told that you had one of the following: (please circle)*** | *Please list any prescription or non-prescription medications you are currently taking, along with dosage and frequency:* |
|---|---|
| LUNG DISORDER YES NO HIGH BLOOD PRESSURE YES NO HEART TROUBLE YES NO NERVOUS DISORDER YES NO DISEASE OF THE DIGESTIVE TRACT YES NO CANCER YES NO KIDNEY DISEASE YES NO DIABETES YES NO ARTHRITIS YES NO HEPATITIS YES NO MALARIA YES NO<br><br>DISEASE OR DISORDER OF THE BLOOD YES NO VISION OR HEARING DISORDERS YES NO ANY LIFE THREATENING CONDITIONS YES NO<br><br>***If you answered yes to any of the above, please describe:***<br>_____<br><br>_____ | _____<br><br>_____<br><br>_____<br><br>_____<br><br>***Please describe any drug sensitivity and allergies:***<br>_____<br><br>_____<br><br>_____ |

Have you been disabled or hospitalized during the last year? If so, please describe:

_____

Have you had or been advised to have a surgical operation within the last five years? If so, please describe:

_____

Date of last physical exam: _____ Date of last: Tetanus Shot _____

Flu Shot _____ Pneumonia Vaccine _____ TB screen _____

Colonoscopy _____ Mammogram _____ Eye Exam _____

*Please list any significant medical problems of your immediate family:*

_____

_____

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**Medical Records**

Patient's Full Name: _____ Date of Birth: _____

Patient's Address: _____ Phone Number: _____

I authorize the release of my medical records **from** the following facility:

Name of Facility: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____ Fax Number: _____

***I authorize the above facility to release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, and/or medical records by means of mail, fax or other electronic methods.***

This authorization is:

[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)

[ ] Genetic information

[ ] Limited to the following medical information: _____

**Authorization:**

**I hereby request that my medical records be released to: Lew Medical**

_____ _____

Signature of patient or *legal/personal representative* Relationship *if other than patient*

*It's the policy of this medical practice that we will adopt, maintain, and comply with our Notice of Privacy Practices, which shall be consistent with HIPPA and California Law*

*Duration: This authorization shall become effective immediately and shall remain in effect until _____ (enter date) or for 1 year from the date of signature if no date entered.*

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