

Patient Partnership Plan

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your best possible health requires a "partnership" between you and your doctor. As our "partner in health," we ask you to help us in the following ways:

Schedule visits with My Doctor for Routine Physical Exams and Other Recommended Health Screenings

I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (electrocardiogram, echocardiogram etc), These health screenings are tests that can help detect life-threatening diseases and conditions. If I visit my doctor only for immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

Keep Follow-up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives her the chance to check my condition and response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do Not Hear the Results of Labs and Other Tests

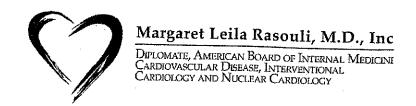
I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

Inform My Doctor if I Decide Not to Follow Her Recommended Treatment Plan

I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that not following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide not to follow her recommendations so that she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite your, at any time, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

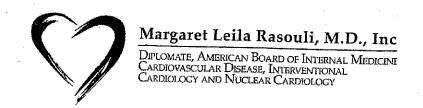
Patient Name	Patient Signature	Date
MI. Rasore		
Physician Name	Physician Signature	Date



Patient Name:	
DOB:	· ·
Date:	

PATIENT INTRODUCTION

Name:			D:	ate of Birth:		Δσε.
(Last)	(First)	(Middle)				Age:
Home Address:						
(Street)	(Apt. No.)	(City)		(State)	(Zip Code)
Home Ph:		Cell Ph:		Other	r Ph:	
Driver's License #:		Social Security	#:		Gender:	MaleFema
E-Mail Address:	<u> </u>		Allerg	ies:		
Marital Status: Single	Married\	WidowedDivor	ced Ethnic	ity:Hispanic	Non-Hispani	icPatient Refus
Primary Language:			Secondary	y Language:		
Race:AsianAm	nerican Indiar	n/Alaska Native	Black/Afr	ican American_	Hawaiian/	Other Pacific
IslanderWhite	Patient Refu	salOther Ra	ce		·	
EMPLOYER INFORMATION						
Employer:		Occupation:		V	Vork Phone#:	
Employer Address:						
(Street)			(City)		(State)	(Zip Code)
REFERRAL INFORMATION						
Referring Physician:				Phone No:		
Primary Care Physician (PCP):				Phone No:		
Oblem Dhoot to				Phone No:	•	
EMERGENCY CONTACT INFOR	MATION *(p	erson not living wi	th you)*			
Name:		Relationsh	ip		HIPPA Conser	nt:YesNo
Address:		<u></u>				
(Street)		(Apt. No.)	(City)	(State)	(Zip Code)
lome Ph:	(Cell Ph:		Other Ph	1:	



Patient Name:	
DOB:	
Date:	

SPOUSE INFORMATION OR RESPONSIBLE PARTY INFORMATION IF PATIENT IS A MINOR

Name:			Date of Bi	irth:	Age:	
(Last)	(First)	(Middle)				
Home Address:					·	
	treet)	(Apt. No.)	(City)	(State)	(Zip	Code)
Home Ph:		Cell Ph:		Driver's Lice	ense #:	
Social Security #:		E-Mail Address:		Ger	nder:Male	Femal
PHARMACY INFORMAT	<u>ION</u>				-	
Pharmacy Name:			Phone	<u>.</u>		<u>-</u>
Address:				٠		
Address:	(Street)	(City)		(State)	(Zip Code)	
PRESCRIPTION INSURAN	ICE INFORMATIC	<u>on</u>				
Subscriber Name:		<u> </u>	RX Insurance Nan	ne:	·	
Insurance Policy No:	·.	····································	Phone:_			
MEDICAL INSURANCE IN	FORMATION		· ·			
Subscriber Name:			Insurance Name	<u> </u>		
nsurance Policy No:			Group No.			
Claims Mailing Address:_				•		
	(Street/P.O. Box)		(City)	(State)	(Zip Cod	ie)
econdary Insurance:						
lame of Insured:	<u> </u>	Nan	ne of Insurance:			
nsurance Policy No:			Group No			
laims Mailing Address:						
_	(Street/P.O. Box)		(City)	(State)	(Zip Code	<u></u>

PATIENT (SELF) CARDIOVASCULAR HEALTH HISTORY

Name:	F	····	
Age:	First Data of Birth	Last	MI
Aye.	Date of RIMI:		Sex: 🗌 Male 🔲 Female
Present or Re	tired Occupation:		Marital Status:
Current Medic	al Symptoms / Complaints:		
** ***********************************			
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	Medications (include dose & h		A Windowski and Control of the Contr
MANIE C	E MEDICATION DO	SEAGE	HOW/WHEN TAKEN
			
			
ase List Ope	rations:		
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MILY HISTOR'	Y:		
mily member		s and their ages. If d	leceased, please give age and cause o
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	V PROPERTY OF THE STATE OF THE	4 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1	EKO BRUTHERS
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e are close r	elatives with a history of heart	disease, high choles	terol, high blood pressure, stroke,
tes, cancer, e	etc., please indicate their relatio	msnip, specific medi	cal condition and their age:

Have you ever Smoked?		If Yes, for I	now many years	?	
Do you drink Alcohol? If you have stopped drinking, how lo	Yes No ong ago?	If Yes, how	manydrinks pe	r week?	
If you are exercising, please list the for 20 minutes):	type of evercise	frequency and	duration (e.g., w	/alking 3 times per week	
Do you follow a special diet?	Yes No	☐ Low Salt	Low Fat		
What was your last cholesterol level?	·	Date Taken:			
Undue Stress Previ	Blood Pressure lous Heart Attack		h Cholesterol pheral Vascular	Overweig Disease	ht
If Female, are you still menstruating Are you Pregnant? If No, do you still use Birth Control?		☐ Yes ☐ Yes ☐ Yes	<u></u>		
Date of Last Chest X-Ray:					
REVIEW OF SYSTEMS: Chest Pain at Rest Chest Pain Exercising Palpitations (Heart Pounding, Racing) Short of Breath at Night / Lying Down At Rest Exercising Calf / Leg Pain with Ambulation Rheumatic Fever Rheumatic Heart Disease Heart Murmur Swelling of Feet or Ankles (Edema) Congestive Heart Failure Dizziness Fainting Cough with or without Sputum Nausea / Vomiting Bloody or Black Stool Hepatitis or Jaundice Easy Bruising or Bleeding Thyroid Disorder Lung Disease Kidney Disease Stroke	Yes	☐ No	Date Began:		
Patient's Signature:			Date	31	
Doctor's Signature:				۲ <u>ــــــ</u>	

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Name:		Date of Birth:
Last	First	Middle
ente provinci i	HATTICA DOLOM TO U	of Information: I voluntarily authorize and direct disclose my health information during the term of ave identified below.
Name of Provider: _ Address of Provider: _		
Fax Number:		
rax Number:		
Recipient and Addres	s for Delivery of	of Records:
•		
Information to be disc provider to disclose the fo	losed: This autollowing medical	nthorization permits the above named health care al records:
treatment received by a testing, psychotherapy controlled substance in	to any medical me, including wit notes and other i formation, billing	e provider has in his or her possession, including history, mental or physical condition and any ithout limitation, x-rays, HIV/AIDS status, genetic mental health information, drug, alcohol or other ng information, correspondence, and records from above-named health care provider may hold.
☐ All of my health inform	ation described a	above except for the following:
☐ Only the following rec types of treatment or oth	ords or types of er designation.)	f health information: (Insert dates of treatment,
erm: This Authorization ithorization is signed.	n will remain in	in effect for one (1) year from the date this

Redisclosure: I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.

Revocation: I understand that the Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider at my health care provider's regular office address. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before the provider received my written notice of revocation.

Questions: I may contact my health care provider for answers to my questions about the privacy of my health information at my health care provider's regular office telephone number. I understand that I have a right to receive a copy of this authorization from my health care provider.

<u>Photocopy</u>: A photocopy, fax or electronic copy of this authorization shall be considered as effective and as valid as the original.

Signature	Date	,	Signature of Witness
Name:			
(Please Print)		10	
If Individual is unable to	sign this Authorization, pl	lease comp	olete the information below.
	•		morniation below.
Signature of Personal Representative	Legal Relationship	Date	Witness Signature
Name:	·		
(Please Print)			

Authorization form

Office of

Margaret Leila Rasouli, M.D

Patient Authorization for Use and Disclosure of Protected Health Information

·	
By signing, I authorize Margaret Leila Rasouli, protected health information (PHI) about me to	M.D to use and/or disclose certain
This authorization permits Margaret Leila Rason following individually identifiable health inform information to be used or disclosed, such as date detail to be released, origin of information, etc.):	uli, M.D to use and/or disclose the nation about me (specifically describe the
The information will be used or disclosed for the	following purpose:
(If disclosure is requested by the patient, purpose individual.")	
The purpose(s) is/are provided so that I can make release of the information. This authorization will I do not have to sign this authorization in order to Margaret Leila Rasouli, M.D. In fact, I have the rig When my information is used or disclosed pursuan subject to redisclosure by the recipient and may no HIPAA Privacy Rule. I have the right to revoke thi extent that the practice has acted in reliance upon the revocation must be submitted to the privacy officer Margaret Leila Rasouli, M.D. 24411 Health Center Dr # 650	receive treatment from, that to refuse to sign this authorization. It to this authorization, it may be longer be protected by the federal as authorization in writing except to the this authorization. My written
Laguna Hills, CA 92653	
Signed by: Signature of Patient or Legal Guardian	Relationship to Patient
Print Patient's Name	Date
Print Name of Patient or Legal Guardian, Patient/guardian must be provided with a signed copy	**



Patient Name:	 	
DOB:	 ······································	-
Date:		·

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

Margaret Leila Rasouli, M.D., Inc. appreciates the confidence you have shown in choosing us to provide for your health care needs. The services you have elected to participate in imply a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill including but not limited to deductible, co-payment and co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurance carrier.

I have read the above policy regarding my financial responsibility to Margaret Leila Rasouli, M.D., Inc. for providing services to me or the above named patient. I hereby authorize Margaret Leila Rasouli, M.D., Inc. to provide medical care and to release my medical information to my insurance company(s) as necessary for the payment of benefits. I also authorize my insurance company(s) to pay benefits directly to Margaret Leila Rasouli, M.D., Inc. These authorizations remain valid and effective from the date of signing until revoked in writing. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I further agree that a photocopy of this agreement shall be as valid as the original.

CONSENT FOR TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Margaret Leila Rasouli, M.D., Inc., through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures. I further authorize Margaret Leila Rasouli, M.D., Inc. to release any information acquired in the course of my or the above named patient's examination and treatment to any/all appropriate agencies.

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

I authorize Margaret Leila Rasouli, M.D., Inc. to view my external prescription history via Surescripts Prescription Service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years. I understand this will allow my providers to better coordinate my care and medication history to maximize the effectiveness and safety of my treatment plan. I certify that I read and understand the scope of my consent and that I authorize the access.

CONSENT TO CONTACT VIA EMAIL

To the extent that our new Electronic Medical Record software allows it, we may be able to contact you via email to remind you of appointments or to share other pertinent information about your healthcare. I authorize Margaret Leila Rasouli, M.D., Inc. to use the email address I provided above to contact me in regard to my healthcare. I consent that protected healthcare information may be transmitted to me via the email address I provide.

MISSED APPOINTMENT POLICY

I understand that Margaret Leila Rasouli, M.D., Inc. does REQUIRE 24 hours advanced notice to cancel or re-schedule an appointment. I understand a fee may be charged to my account for missed appointments.

REQUESTS

l understand that Margaret	t Leila Rasouli, M.D., Inc. ma	ay charge a fee for any re	ecord requests, letter re	guests and form fill.
out requests.	,		[quests and form fill-

•			
(Signature)	•	· · · · · · · · · · · · · · · · · · ·	
		(Date)	
		(oute)	

Margaret L. Rasouli, M.D.

24411 Health Center Drive #650 Laguna Hills CA 92653 P: (949) 600-7228 | F: (949) 600-7229

Notice of Privacy Practices Acknowledgment

We understand that medical information about you and your health is personal. As the custodians of the information in your medical record, we are committed to protecting the privacy of your information as required by law professional accreditation standards and our internal policies and procedures.

Attached is your personal copy of your Notice of Privacy Practice. This notice explains your rights, our legal duties and our privacy practices. It also describes how much medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

For your convenience the following is a summary of the information discussed in the notice:

- Our Pledge
- Your personal information
- Our Privacy Practices
- Your written permission
- Other restrictions
- Your rights
- Changes
- Questions or Complaints

We may use your information for:

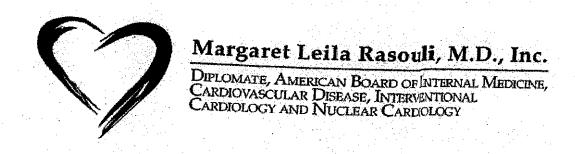
- Treatment
- Health Information Exchange
- Payment
- Health Care Operations
- Notifications
- Marketing Research
- Special circumstance & the law

Please understand that this summary is not our Notice of Privacy Policies, nor is it a substitute for the notice. The actual notice should have been given to you, as required by law, with this cover letter. If it was not, please contact our office manager at the address or phone number above to receive your copy.

We ask that you sign and return this cover letter to us for our records. Your signature only acknowledges that we have provided you a personal, paper copy of our Notice of Privacy Practices as required by law. The law also requires us to document the fact that we have distributed the notice by collecting and retaining this signed acknowledgment. If, after reviewing the notice, you decide that you do not want to retain your copy, please return it to our receptionist and we will recycle it.

I hereby acknowledge receipt of the Notice of Privacy Practices and the office policies & procedures and do with to receive treatment:

Signature	Printed Name	
o-Bridear c	Thited Hame	Date



CANCELLATION AND NO SHOW POLICY

Our goal is to provide quality individualized medical care. "No-shows" and late cancellations inconvenience those individuals who need access to medical care in a timely manner. As of <u>April 1, 2016</u>, we have enforced cancellation/missed/no show fees. We would like to remind you of our office policy regarding missed appointments. This policy enables us to better utilize available appointments for our patients in need of medical care.

Cancellations

We know that your time is valuable and that there may be special unavoidable circumstances that may cause you to cancel, however in order to be respectful of the medical needs of other patients, please be courteous and call our office promptly at 949 600-7228 to cancel your appointment.

Please understand that when we schedule your appointment, we are reserving time for your particular needs. We kindly ask that if you must change or cancel an appointment, please notify us **no less than 24-hours** (1 <u>business</u> days).* For example, if the appointment is on Wednesday at 2 p.m., it must be cancelled no later than Tuesday at 2 p.m.* This courtesy makes it possible to give your reserved time to another patient who is in need of our care.

Missed/No Show Appointments

We understand that occasional missed appointments can occur for a variety of reasons. A "No Show/Late Cancellation" is defined as missing an appointment without cancelling, **24-hours** (1 <u>business</u> days) before your scheduled time.

Cancellation/Missed/No Show Appointment Fee

Office appointments which are cancelled with less than 24 business hours will be subject to a fifty dollar (\$50.00) cancellation fee. Diagnostic appointments (i.e. Echocardiogram, Stress Test) with notice of less than 24 business hours will be subject to a fifty dollar (\$50.00) cancellation fee.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication

Thank you.		
Signature	Date	