Welcome to our office

Personal information

Name First _____ M.I. _____ Last _____

Address _____

City _____ State _____ Zip Code _____

Tel # Home _____ Office _____ Mobile _____

Email _____

SS # _____ Drivers license _____ State _____

Birthdate Sex O M O F

Employer Employer's phone #

Spouse's Name _____ Birthday _____ SS # _____

Spouse's tel numbers Office Mobile

Emergency Contact tel numbers

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

Name Relationship Phone #

Name of pharmacy : Local Mail order phone number

Who may we thank for referring you ?

Name of Primary Insurance

Information about person who is responsible for account (if other than your self or your spouse)

Name First _____ M.I. _____ Last _____

Address (if different from yours) _____

Birthday _____ SS # _____

Relationship to patient O Spouse O Other (please specify)

Name of Secondary Insurance

Information about person who is responsible for account (if other than your self or your spouse)

Name First _____ M.I. _____ Last _____

Address (if different from yours) _____

Birthday _____ SS # _____

Relationship to patient O Spouse O Other (please specify)

Assignment and release

I assign and request payment of medical benefits to Compassionate Doctors for services rendered

I hereby authorize the doctor to release all information necessary to secure the payment of benefits

I authorize the use of this signature on all insurance submissions

Signature Date

Updated on						

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION
(MEDICAL RECORDS REQUEST)

Patient Name: _____ Date of Birth : _____

☒ **I authorize** Iresha Goonesinghe MD of Compassionate Doctors Medical Corporation 301 W Drummond Avenue, Ridgecrest, CA 93555 Tel: (760) 371-3008 FAX: (760) 371-3009 **to obtain information from**:

_____

_____

_____

☒ **I authorize** Iresha Goonesinghe MD of Compassionate Doctors Medical Corporation **to release information to** my health insurance Company/s **for billing purposes**

☒ **To :** (Name of Institution) _____

_____

_____

Please release my medical information to Iresha Goonesinghe MD of Compassionate Doctors Medical Corporation

☐ **I authorize** Iresha Goonesinghe MD of Compassionate Doctors Medical Corporation **release information to**

_____ **Initial** _____

_____ **Initial** _____

_____ **Initial** _____

☐ Purpose of request for information : Health Care and Health Insurance billing

☐ This authorization will ☒ Not Expire ☐ Expire on specified date: _____

☐ Information to be released :

☒ **All** of my records

☐ **Only** the following records or types of health information (please specify)

_____

_____

_____

NOTICE OF RIGHTS AND OTHER INFORMATION

I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the address above. My revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance upon this authorization. I may refuse to sign this authorization. I have a right to receive a copy of this authorization. Neither treatment, payment, enrollment or eligibility for benefits will be conditioned on my providing or refusing to provide this information.

Information disclosed pursuant to this authorization could be re- disclosed by the recipient and might no longer be protected by federal confidentiality law(HIPPA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law. I may inspect or obtain a copy of the health information that is being requested or disclosed.

Signature:_____ Date : _____

If other than patient please sign here:

Name: _____ Relation: _____

Signature:_____ Date : _____

Name _____

How old are you _____

		Yes	No	How long
Do you have	Hypertension (High Blood Pr)			
	Diabetes			
	Stroke			
	Kidney problems			
	Liver problems			
Other medical problems	_____			
Other medical problems	_____			

Have you had	Heart attacks	When?	
	Angiograms	When?	
	Angioplasty	When?	
	Open heart surgery	When?	

	Yes	**No**
Do you have chest pains?		
Do you get short of breath?		

How far can you walk before you get short of breath

	1	>1
How many pillows do you use at night		
Do you wake up at night because you cannot breathe ?		
Do you feel your heart beat funny?		
Do you get swelling in your feet?		
Do you get pain in your legs when you walk?		

How far can you walk before you get pain? _____

	Yes	No
Do you cough on a regular basis?		

	Yes	No
Do you have problems swallowing?		
Do you have stomach pains?		
Do you have heart burn?		
Are you constipated?		
Do you have frequent diarrhea?		
Have you had a bowel motion that is black in color?		
Have you ever vomited blood?		

Name _____

Do you have any problems passing urine?	Yes	No
When was your last prostate exam		
Have you had any menstrual problems	Yes	No
When was your last PAP smear		
When was your last mammogram		

Have you had any recent fainting spells?	Yes	No
Do you have any seizure disorders like epilepsy		
Have you had any recent numbness or weaknesses		

Please list all your medications including over the counter medications, vitamins and herbal medications

Name	Dosage	Name	Dosage

List all your allergies _____

Please list all the operations you have had

Type	Year	Type	Year

Name _____

Do any of your family members (father, mother, grand parents, children, aunts and uncles etc.) suffer from

Diabetes Heart disease Other

Hypertension Cancer

Are you O Single O Married O Widowed O Divorced

If so for how long ? _____

Do you have children? O Yes O No If so how many ? Daughters _____ Sons _____

Do you have any children who live in Ridgecrest? O Yes O No

Have you ever smoked cigarettes? If so how many per day? _____ For how long? _____

When did you stop smoking ? _____

How much alcohol do you take ? _____

Have you ever used any illicit drugs ? If so when ? _____ What kind? _____

What kind of work do you do ? _____

Are you retired? If so when? _____

What kind of work did you do before you retired? _____

Are you on disability? If so what kind of disability do you have? _____

What kind of work does your spouse do ? _____

PHYSICIAN-PATIENT 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 or negligently or incompletely 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 right 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 services provided by the physician including any spouse of 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 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. However, following the assertion of any claim against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **ATTORNEY'S FEES AND COSTS**: Any party to this Arbitration Agreement who files an action for medical malpractice in any municipal or superior court shall be liable to any other party for attorney's fees and costs incurred in responding to and defending said action.

All attorney's fees and expenses incurred by a party of the arbitration shall be borne by that party.

Article 4: **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 (30) days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty (30) days thereafter. 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 incurred by a party of such party's own benefit.

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 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, Section 667.7. Civil Code Section 3333.1 and Section 3333.2.

Article 5: **GENERAL PROVISIONS**: All claims based upon the same incident, transaction or related circumstances shall be asserted in a civil action, would be barred by the applicable California Statue 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 arbitration shall be governed by California Code of Civil Procedure provisions relating to arbitration.

Article 6: **REVOCATION**: This agreement may be revoked by written notice delivered to the physician within thirty days of signature and, if not revoked, will govern all medical services received by the patient.

Article 7: **RETROACTIVE EFFECT**: If the patient intends this agreement to cover services rendered before the date it is signed (for example emergency treatment) the patient should initial below:

Effective as of the date of first medical services.

_____
Patient's Initials

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

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.

IRESHA GOONESINGHE M.D.
Print or Stamp Name of Physician
Medical Group or Association

_____
Physician or Duly Authorized Representative

Translated by (if applicable):

_____
Signature (Date)

_____
Print Name

_____
Patient (Date)

_____
Patient's Agent or Representative (Date)

_____
Relationship to Patient

A signed copy of this document is to be given to the patient. The original is to be filed in Patient's Medical Record.

DNW

Notice of Privacy Practices Patient Acknowledgement Form

Patient Name:_____Date of Birth:_____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information.

Compassionate Doctors has implemented the following to protect and safeguard my health information:

- Continued training all employees on privacy policies and procedures
- Established safeguards to protect all electronically stored data

Compassionate Doctors will only use my personal information for:

- Planning care and treatment
- Communication with other health care professionals who may contribute to my care
- Communication with my insurance provider

Compassionate Doctors does requests my permission to:

- Have a Sign in sheet at the front desk – in which my name may be visible to other patients
- Call my daytime phone number to confirm appointments
- Call out my name at the time of my appointment
- Send email reminders for appointments
- Send patient medical records via public email if requested by you or your legal representative

Compassionate Doctors will get my written permission if they were to use my personal information for any other reasons other than the minimum necessary. My individual rights, with respect to protected health information, provide me with the right:

- To revoke this consent in writing, except to the extent that Compassionate Doctors has already taken action in reliance thereon.
- To inspect, amend, request restrictions in writing, get copy of my medical information, and information about the disclosure they have made on my behalf
- To complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.

By signing this agreement I acknowledge that I have read and understand this practice's Notice of Privacy Practices. Please do not hesitate to contact our privacy officer at (760) 371-3008 option 5 if you have any questions, concerns or suggestions. Updates to this policy will be available online at www.onlinemedoffice.net.

_____ _____

Signature of Patient or Legal Representative Witness Date

Compassionate Doctors Medical Corporation

Our Billing Policy

(Updated August 2010)

*We strongly believe that **your** peace of mind is very important to **your** general well-being and health.*

Therefore, we have created a very simple billing policy for our Corporation.

- *Please pay your co-pay at the time of your visit. You will save time, postage and paper. We currently accept personal checks, credit cards and cash (exact change please). You will also help us to cut down our administration costs significantly.*

- *If you cannot afford to pay your co-pay, please let us know. We will never send you to a collection agency or penalize you in any way.*

- *All insurance companies require us to bill you for the deductibles, co-payments and co-insurance amounts. However, if you cannot afford to pay the balance please call our billing department.*

Get rid of stress, Stay healthy and Enjoy life....

The Management Team
Compassionate Doctors Medical Corporation

For your information Dr Iresha Goonesinghe is:

- *A Fellow of the American College of Cardiology.*
- *A Fellow of the American College of Physicians.*
- *A Member of the American College of Physician Executives.*
- *Is licensed and regulated by the Medical Board of California. (800) 633-2322 www.mbc.ca.gov*

I have read and understand the contents of this document.

_____

Signature *Date*

_____

Print Name *DOB*