PalosVerdesMedicalGroup

NEW PATIENT INFORMATION

Patient Name: _________________________________ Sex: DOB: ________________________
Address: ______________________________________ City: _______________________ Zip Code: _______
Home Number: _________________________________ Cell Number: _________________________________
Email: ____
Emergency Contact: _______________________________ Phone Number: _____________________________
Race: Ethnicity:
How did you hear about us?
Do we have permission to email you health-related information and news?

Insurance Information Please fill out **COMPLETELY.** If you don't have insurance, please indicate.
Name of Insured: __________________________________ DOB: ____________________
Relationship to Patient: ____
Employer: ____
Insurance Company: ____
Claims Address: ____
City: ____ Zip Code: ______________________
Phone: _____________________________________
Subscriber ID#: _________________________ Group #: ____________________________

Secondary Insurance
Name of Insured: __________________________________ DOB: ____________________
Relationship to Patient: ____
Employer: ____
Insurance Company: ____
Claims Address: ____
City: ____ Zip Code: ______________________
Phone: _____________________________________
Subscriber ID#: _________________________ Group #: ____________________________

I authorize this office to use information provided for treatment, payment and to conduct normal healthcare operations. I understand that if payment by the insurance carrier is not received for any reason, that I am responsible for payment in full.

Signature: _____________________________________ Date: _____________________

550 Deep Valley Drive, Suite 319 | Rolling Hills Estates, CA 90274 | Tel: 310-544-6858 Fax: 310-544-6885

CONSENT TO USE TELEMEDICINE

My primary residence is in California. At the beginning of each telemedicine session, I will help my doctor to complete a check-in to assess the suitability of using telemedicine services by verifying my full name, my current location, my readiness to proceed, and whether I am in a situation conducive to private, uninterrupted communication. By signing this consent, I understand and agree:

1. My doctor is located in and licensed by the State of California. My doctor may not be able to prescribe medications for me and/or may not be able to assist me in an emergency situation when I am located in any other state or country. If I requite medication, I may contact my doctor. If I require emergency care, I may call 911 or proceed to the nearest hospital emergency room for help.

2. I submit to the exclusive jurisdiction of the California stats superior courts and agree that any claim, lawsuit, or other legal proceeding arising out of or relating to the telemedicine services provided by my doctor and my doctor's staff will be brought solely and exclusively in California state superior courts. I also agree that the interpretation of this consent will be exclusively governed by and constructed in accordance with the laws of California.

3. My doctor believes that telemedicine services are appropriate for my medical condition and that I would benefit from its use despite its risks and limitations. While I may expect anticipated benefits from the use of telemedicine, no specific results can be guaranteed or assured.

4. If my doctor believes at any time that another form of services (for example, a traditional in-person consultation) would be appropriate, my doctor may discontinue telemedicine series and schedule an in-person consultation with my doctor or refer me to a healthcare provider in my area who can provide such services.

5. I have the right to withdraw consent to the use of telemedicine services at any time and receive in person healthcare services with my doctors.

6. I received an explanation of how the electronic communications technology will be used for the telemedicine services. I am comfortable with using electronic communications technology to communicate with my doctor and understand there are limitations to the technology which may require an in-person consultation.

7. I agree to have the necessary computer, equipment and internet access for my telemedicine communications. I also agree to arrange for a location with sufficient lighting and privacy and is free from distractions and intrusions during my telemedicine communications.

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CONSENT TO USE TELEMEDICINE

8. The laws that protect privacy and the confidentiality of my medical information also apply to telemedicine. The medical information that is transmitted electronically by my doctor to me will be encrypted during transmission and will be stored only by my doctor or a service provider selected by my doctor. I understand the dissemination of any personally-identifiable images or information from the telemedicine communication to researchers or other healthcare providers will not occur except as required by federal or California state law.

9. I understand my risks of a privacy violation increase substantially when I enter information on a public access computer, use a computer that is on a shared network, allow a computer to "auto remember" usernames and passwords, or use my work computer for personal communications. I also understand it is my responsibility to encrypt medical information I transmit electronically to my doctor and my failure to use technical safeguards, such as encryption, increases my risks of a privacy violation.

10. I have the right to access my medical information and obtain copies of my medical records in accordance with California law.

11. I understand that the telemedicine services provided to me will be billed to my health insurance company and that I will be billed for any patient responsibility as per my insurance.

I read and understand the information provided in this Consent to Use of Telemedicine. I discussed any questions I had with my doctor and all of my questions were answered to my satisfaction.

____
Patient's Printed Name

____
Patient's Signature

____
Date

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PalosVerdesMedicalGroup

INSURANCE POLICIES & CASH PRICES: COVID-19

Thank you for choosing Palos Verdes Medical Group. This notice is to inform you of our insurance policies in relation to COVID-19 testing as well as the cash prices for COVID-19 testing.

We do not verify your insurance coverage prior to you receiving services at our office. It is your responsibility to make sure that we are in network for your plan. We recommend that you call your insurance company to verify that both telemedicine (which we require prior to COVID testing) and COVID-19 testing are a covered benefit. You will need to check what your share of cost or copayment may be. You can find this information by calling the member service phone number on your insurance card or checking the insurance plan website. If you have an HMO, you must have Optum Healthcare South Bay or Little Company of Mary (also known as HealthCare Partners) as your IPA or medical group to be considered in network.

To find out if we are in network for your plan, our billing physician information is as follows: ***Lawrence D. Sher, M.D. NPI#1912923913***. You will want to make sure Dr. Sher in-network provider for your plan.

To verify if telemedicine is covered, you will need to ask your insurance company if the following service is covered under your plan: ***Telemedicine: Code 99203- modifier 95- place of service 02***

If you choose to have antibody testing, please note that we are not billing antibody tests to your insurance unless you have Medicare. **You will need to pay the fee for this test at the time of service.**

If you **are out of network, if these services are not covered by your insurance, or if you do not have insurance coverage at all**, the following are our **cash prices**. These fees will be collected at the drive through COVID-19 testing site:

1. COVID-19 nasal swab (results in 2-4 days): **$175.00**
2. COVID-19 Rapid Test – Abbott ID Now or Cepheid (same day results): **$175.00**
3. Antibody Test – finger prick (same day results): **$175.00**

Optum Care Network Insurance (HMO) – Cash Prices:

1. COVID-19 Rapid Test – Cepheid (same day results): **$100.00**
2. Antibody Test – finger prick (same day results): **$50.00**

I read, understand & accept the information provided above.

______________________________ ______________________________

Patient's Signature Date

______________________________ ______________________________

Patient's Printed Name Patient's DOB

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PalosVerdesMedicalGroup

NOTICE OF PRIVACY PRACTICES

This notice describes how your medical information as a patient of this practice may be used and disclosed and how you can get access to this information.
Please review it carefully.

The privacy of your medical information is important to us. You may be aware the U.S. government regulators established a privacy rule, the Health Insurance Portability & Accountability Act ("HIPAA") governing protected health information ("PHI"). PHI includes individually identifiable health information including demographic information and relates to your past, present or future physical and mental health or condition and related health care services. This notice tells you about how your PHI may be used, and about certain rights that you have.

Use and Disclosure of Protected Information

- Federal law provides that we may use your PHI **for your treatment**, without further specific notice to you, or written authorization by you. For example, we may provide laboratory or test data to that specialist.
- Federal law provides that we may use your medical information **to obtain payment** for our services without further specific notice to you, or written authorization by you. For example, under a health plan, we are required to provide the health insurance company with a diagnosis code for your visit and a description of the services rendered.
- Federal law provides that we may use your medical information **for health care operations** without further specific notice to you, or written authorization by you. For example, we may use the information to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.
- We may use or disclose your medical information, without further notice to you, or specific authorization by you, where:
    1. required for public health purposes
    2. required by law to report child abuse
    3. required by a health oversight agency for oversight activities authorized by law, such as the Department of Health, Office of Professional Discipline or Office of Professional Medical Conduct
    4. required by law in judicial or administrative proceedings
    5. required for law enforcement purposes by a law enforcement official
    6. required by a coroner or medical examiner
    7. permitted by law to a funeral director
    8. permitted by law for organ donation purposes
    9. permitted by law to avert a serious threat to health or safety

Obligations That We Have

- We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices. We are required to abide by the terms of this notice as long as it is currently in effect.
- We reserve the right to revise this notice, and to make a new notice effective for all protected health information we maintain. Any revised notice will be posted in our office, and copies will be available there.
- We will inform you of our intentions to raise funds and your right to opt out of receiving such communications.
- If you believe these privacy rights have been violated, you may file a written complaint with our Privacy Officer or with the U.S. Department of Health and Human Services' Office for Civil Rights (OCR). We will provide the address of the OCR Regional Office upon your request. No retaliation will occur against you for filing a complaint.

Organization Contact Information

IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:
Palos Verdes Medical Group
Address: 550 Deep Valley Drive, Suite 319, Rolling Hills Estates, California, 90274
Telephone Number: 310-544-6858 extension 232
Contact Person: Michelle Smith

I, ____, have received a copy of Palos Verdes Medical Group's Notice of Privacy Practices.

_________________________	_________________________
Patient Name	Date
_________________________	_________________________
Responsible Party Signature	Date