MY CONCIERGE MD
Executive Health

Medical History Questionnaire • Confidential Information

PATIENT INFORMATION

Name _____ DOB _____ Age _____
Home/Cell Phone (_____) _____ Email _____
Address _____
City _____ State _____ Zip _____
Social Security # _____-_____-_____ Driver's License # _____ State _____
Employer _____ Business Phone (_____) _____
Address _____
City _____ State _____ Zip _____
Occupation _____
Marital Status ❑Single ❑ Married ❑ Widowed ❑Separated ❑Divorced
Ethnicity ❑Caucasian ❑ African American ❑ Asian ❑Hispanic ❑Middle Eastern ❑ Other
How did you learn about My Concierge MD?
In Emergency – Contact Name _____ Phone (_____) _____

PHARMACY INFORMATION

Pharmacy Name _____ Phone (_____) _____
Address _____
City _____ State _____ Zip _____

SPOUSE OR RESPONSIBLE PARTY INFORMATION

Spouse/Responsible Party _____ DOB _____
Home/Cell Phone (_____) _____ Email _____
Address _____
City _____ State _____ Zip _____
Social Security # _____-_____-_____ Driver's License # _____ State _____

INSURANCE INFORMATION

Do you have medical insurance? ❑Yes ❑No If yes, please complete the following:
Insured's Name _____ DOB _____
Relationship to the insured: ❑Self ❑Spouse ❑Child ❑Other
Primary Insurance _____ Policy # Insurance Holder _____
Secondary Insurance _____ Policy # Insurance Holder _____

RELEASE ASSIGNMENT

I hereby authorize My Concierge MD or designee to disclose when requested by the above named/attached medical insurance carrier or its representative or any other insurance entity and all information with respect to any illness, injury, medical history, or treatment and copies of all medical records. A Photo Static copy of this authorization shall be as effective and valid as the original.

Signed _____ Date _____

I hereby authorize payments and/or medical benefits to My Concierge MD or designee for professional services rendered to me. I understand that I am financially responsible for charges not covered by this authorization. A photo static copy of this authorization shall be considered and effective as the original, although I have requested the physician to bill my medical insurance carrier on my behalf as a courtesy to me, I clearly understand that it is my responsibility to make sure that the bill is paid in a reasonable time. If for any reasons any portion of my bill is not paid by my insurance. I further agree to make arrangements for prompt payment of the bill.

Signed _____ Date _____

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Name: Date:

MEDICAL INFORMATION

Reason for visit:

_____

_____

_____

PAST & PRESENT MEDICAL HISTORY: Please list all current medical problems (ie. High Blood Pressure, Diabetes, etc...)

Medical Problem	Year Diagnosed

PAST SURGICAL HISTORY

Surgery	Date

MEDICATIONS

Medication name	Dose	How Often

ALLEGIES

Are you sensitive/allergic to any medications? ❑Yes ❑No

If yes, please list: _____

If yes, what happens? _____

FAMILY HISTORY

	Living?		Age/of Death	Medical Problem
Mother	❑Yes	❑No		
Father	❑Yes	❑No		
Brother(s)	❑Yes	❑No		
Sister(s)	❑Yes	❑No		
Children	❑Yes	❑No		

Do you have a family history (parents, siblings, children) of:

	YES	NO
Heart Attack	❑	❑
Cancer	❑	❑
Diabetes	❑	❑
Stroke	❑	❑

If yes, which family member? _____

SOCIAL HISTORY

Do you drink alcohol? ❑Yes ❑No

If yes, how often? _____

Have you ever smoked? ❑Yes ❑No

Do you smoke now? ❑Yes ❑No

If yes, how many packs per day? _____

Have you ever used recreational drugs? ❑Yes ❑No

Do you use recreational drugs now? ❑Yes ❑No

If yes, what type of drugs? _____

FEMALE HISTORY

Number of pregnancies you have had: _____

Number of abortions/miscarriages: _____

Number of children you have: _____

Ages of your children: _____

Age at first menustration: _____

How many days apart are your periods? _____

How long do your periods last? _____

Are you currently taking birth control pills? _____

Age at menopause?: _____

PREVENTIVE MEDICINE – When was your last:

Colonoscopy _____

Mammogram _____

Pap smear _____

Breast Exam _____

Prostate exam/PSA _____

Self testicular exam _____

Flu shot _____

Pneumonia vaccine _____

Cardiac Stress Test _____

MISCELLANEOUS

Birthplace: _____

How long have you lived in this area: _____

Have you ever had a job/hobby involving plastics, chemicals, sandblasting or industrial dusts? ❑Yes ❑No

If yes, please describe: _____

Have you traveled to any second or third world countries in the last 2 years? ❑Yes ❑No

Would you like to be tested for sexually transmitted diseases? ❑Yes ❑No

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Name: Date:

MEDICAL INFORMATION

REVIEW OF SYSTEMS: Please check all that apply:

	YES	NO
GENERAL		
Fever	☐	☐
Chills	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Unexplained weight loss	☐	☐
SKIN		
Rashes	☐	☐
Lumps	☐	☐
Color change	☐	☐
Dry skin	☐	☐
Hair loss	☐	☐
Irregular moles	☐	☐
HEAD		
Headaches	☐	☐
Dizziness	☐	☐
EYES		
Blurry vision/Double vision	☐	☐
Eye pain	☐	☐
EARS		
Difficulty hearing	☐	☐
Ear ringing	☐	☐
Ear pain	☐	☐
NOSE		
Runny nose	☐	☐
Nose bleeding	☐	☐
THROAT		
Sore throat	☐	☐
Difficulty swallowing	☐	☐
BREASTS		
Breast lumps	☐	☐
Breast tenderness	☐	☐
Nipple discharge	☐	☐
LUNGS		
Shortness of breath	☐	☐
Wheezing	☐	☐
Cough	☐	☐
Sputum production,	If yes, what color: _____	
Tuberculosis	☐	☐
Night sweats	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
CARDIOVASCULAR		
Chest pain	☐	☐
Palpitations	☐	☐
Heart murmur	☐	☐
Heart attack	☐	☐
Chest pain with walking	☐	☐
Shortness of breath with lying down	☐	☐
Shortness of breath with exercise	☐	☐
Leg swelling	☐	☐
GASTROINTESTINAL		
Abdominal pain	☐	☐
Heartburn	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Abnormal stool	☐	☐
Blood in stool	☐	☐
Hepatitis	☐	☐
Yellow skin	☐	☐
URINARY		
Burning with urination	☐	☐
Increased frequency of urination	☐	☐
Blood in urine	☐	☐
Urination at night:	If yes, how many times per night? _____	
MALE REPRODUCTIVE		
Erectile dysfunction	☐	☐
Decreased libido	☐	☐
Genital sores	☐	☐
Testicular pain	☐	☐
Testicular lumps	☐	☐
FEMALE REPRODUCTIVE		
Genital sores	☐	☐
Vaginal itching	☐	☐
Vaginal pain	☐	☐
Vaginal bleeding	☐	☐
Excessive body/facial hair	☐	☐
Breastfeeding	☐	☐
Pregnant	☐	☐
Rheumatologic	☐	☐
Joint pain	☐	☐
Joint stiffness	☐	☐
Weakness	☐	☐
Dry mouth	☐	☐
METABOLIC		
Excessive hunger	☐	☐
Excessive thirst	☐	☐
Excessive heat intolerance	☐	☐
Excessive cold intolerance	☐	☐
Tremor	☐	☐
Change in skin pigmentation	☐	☐
Hematologic	☐	☐
Bleeding problems	☐	☐
Easy bruising	☐	☐
Transfusion reactions	☐	☐
NEUROLOGIC		
Convulsions	☐	☐
Paralysis	☐	☐
Involuntary movements	☐	☐
Numbness	☐	☐
Epilepsy	☐	☐
Memory difficulty	☐	☐
Speech difficulty	☐	☐
Anxiety	☐	☐
Depression	☐	☐

Is there anything not listed on this form that you would like to tell us?

_____

_____

Notice of Privacy Practices

To our patients. This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Our commitment to your privacy
Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.
We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances
The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials, if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records, but not including psychotherapy notes. You must submit your request in writing to David Nazarian, M.D 2080 Century Park East #1405, Los Angeles, CA, 90067 or contact number 310 400-0362.
4. You may ask us to amend your health information if you believe it is correct or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to David Nazarian, M.D 2080 Century Park East #1405, Los Angeles, CA. 90067 or contact number 310 400-0362. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practice. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the department of Health and Human Services. To file a complaint with our practice, contact David Nazarian, M.D 2080 Century Park East #1405, Los Angeles, CA, 90067 or contact number 310 400-0362.. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact David Nazarian, M.D 2080 Century Park East #1405, Los Angeles, CA, 90067 or contact number 310 400-0362.

I hereby acknowledge that I have been presented with a copy of My Concierge MD Notice of Privacy Practices.

Signature _____ Date _____

Printed Name _____

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STATEMENT OF FINANCIAL RESPONSILIBTY

I am informed that My Concierge MD may be an out-of-network provider for my insurance company. My insurance company may process the claims according to my out-of-network benefits and subject to co-insurance and deductible. I will be personally financially responsible for all services not covered by my insurance company.

_____Initial

I acknowledge that my insurance company may send reimbursement check directly to the member. In this case, the member will need to endorse the back of the check with my signature and forward the signed check(s), together with a copy (copies) of the Explanation of Benefits (EOB) to My Concierge MD at the address below.

_____Initial

I acknowledge that failure of the member to remit any of these checks to My Concierge MD within five (5) business days of receipt will results in my account going into default, and I may be assessed a collection fee 30% and an interest fee of 10% per month (or the maximum amount allowed by law) during the time that the check(s) is (are) not forwarded to My Concierge MD.

_____Initial

I have read, understand and acknowledge the above information and by signing below, I agree to all terms contained herein.

Patient Name:_____

Patient Signature:_____Date: _____

Name Witness:_____Date:_____

If the Health Plan Member is not the patient, please enter the following information:

Member Name:_____Occupation:_____

Employer Name:_____Employer Phone#: (___)_____

Employer Address:_____

Employer City:_____State:_____ZipCode:_____

Member Signature:_____Date:_____

9301 Wilshire Blvd. Suite#405A
Beverly Hills, CA 90210
T: (310)-299-8959 • F: (310)-492-9839
info@myconciergemd.com
MYCONCIERGEMD.COM

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Financial Policy

Effective May 1, 2010 **Patient Name:**_____

Thank you for choosing My Concierge MD as your health care provider. **Please carefully read and initial by each statement and sign below.** This policy has been put in place to ensure that financial payments due are recovered to allow us to continue to provide quality medical care for our patients. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our practice manager or billing department will be glad to discuss these policies with you.

1. _____ I understand that if I do not have my insurance card, referral, and / or co-payments, that my appointment may be rescheduled until such time that I can provide the required documents or payments.

2. _____ I understand that My Concierge MD will collect all copayments at the time of visit and any procedure deductibles and coinsurance up to an amount equal to payment in full for the planned procedure code. Payment in full and expected coinsurance payment responsibility are determined by the anticipated billing code(s), details of your insurance policy, and agreement between your insurance company and My Concierge MD. Any overpayment to your account will be refunded to you at your request after payment and/or remittance has been received from your insurance company.

3. _____ I understand that a $25 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. NSF checks must be redeemed with certified funds (cashier's check, money order, or cash.)

4. _____ I understand that if I am unable to make a scheduled appointment I need to contact My Concierge MD at least 24 hours before my scheduled appointment time. Due to a high demand for appointments, missed appointments prevent us from scheduling appropriately and keep others in need of urgent care from being seen. A $25 FEE WILL BE ASSESSED FOR ALL MISSED APPOINTMENTS & $50 FOR MISSED PROCEDURES NOT CANCELED WITH AT LEAST 24-HOUR ADVANCED NOTICE.

5. _____ I understand that if my account is not paid in full within 90 days of a statement date, a 35% collection agency processing fee will be added to the outstanding balance and will be turned over to collections for further processing. No additional appointments will be made for delinquent accounts until they are brought current.

6. _____ My Concierge MD will allow 60 days from the date of filing for my insurance company to process or pay a claim. State law allows insurance companies operating in the state no more than 60 days to process claims. It is my responsibility to provide my insurance company with requested information needed to process a claim for services. It is also my responsibility to notify My Concierge MD if there is any change in my insurance coverage, residence, or phone number. ULTIMATELY, IT IS UP TO ME TO KNOW MY INSURANCE BENEFITS.

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I have read and agree to all the provisions of the above financial policy. I understand that I am ultimately responsible for all professional fees incurred for professional services performed by the attending physician.

Signature of Responsible Party:_____ **Date:**_____

ASSIGNMENT OF BENEFITS

We require insured patients to complete assignment of benefits authorizing insurance to remit payment to physician's office.

I hereby assign all medical and /or surgical benefits to include major medical benefits to which I am entitled, private insurance, and any other health plans to: My Concierge MD. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges where or not paid by said insurance. I hereby authorize said assignee to release all medical information necessary to secure the payment.

Signature of Responsible Party:_____ **Date:**_____

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