

Corona Family Care

341 Magnolia Avenue Suite 201 ~ Corona, CA 92879

Phone: (951) 735-9211 ~ Fax: (951) 735-9299

Patient Information:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

SSN: _____

Driver's License# _____

Employer Name _____

Today's Date: _____

Date Of Birth: _____

Home Phone: () _____

Work Phone: () _____

Cell Phone: () _____

Marital Status S M W D

Gender F M

Local Emergency Contacts:

Name: _____

Relationship: _____

Home Phone: () _____

Cell Phone: () _____

Name: _____

Relationship: _____

Home Phone: () _____

Cell Phone: () _____

Primary Medical Insurance Information:

Insurance Company: _____

Effective Date: _____

Subscriber' Name: _____

DateBirth: _____

Address: _____

Home Phone: () _____

City: _____ State: _____ Zip: _____

Work Phone: () _____

Subscriber # _____ Group # _____

SSN: _____

Secondary Medical Insurance Information:

Insurance Company: _____

Effective Date: _____

Subscriber' Name: _____

DateBirth: _____

Address: _____

Home Phone: () _____

City: _____ State: _____ Zip: _____

Work Phone: () _____

Subscriber # _____ Group # _____

SSN: _____

How did you hear about our office? _____

CORONA FAMILY CARE, INC

341 MAGNOLIA AVE. #201 CORONA, C.A. 92879
PHONE(951)735-9211 FAX(951)735-9299

Jeffery A. Muller M.D.
Family Practice

Anthony Pinner PA-C
Family Practice

November 10, 2011

Advanced Health Care Directive

Dear Patient,

As your Physician, we are required to ask any patient over the age of 18, if they have an existing Advance Health Directive, so that we can incorporate the information into your medical records. You are not required to give us this information but we are required to ask. Please complete this form and return it to the receptionist.

Thank You!

Patient Name: _____ SS#: _____

Patient Signature: _____ Date: _____

I decline to answer the question Yes No

Do you have an Advance Health Care Directive Yes No

If yes, please indicate what type of Directive Yes No

- Durable Power Of Attorney
- California Natural Death Act
- Other: _____

Will you bring a copy of your Directive into our office for your medical chart Yes No

Internal Office Use ONLY

Type of Health Care Directive Received _____ Date Received _____

Durable Power of Attorney for Health Care

California Natural Death Act

Living Health Care Will

Other: _____

Corona Family Care, Inc.

341 Magnolia Ave. Ste. 201 Corona, CA 92879

Phone: (951) 735-9211 Fax: (951) 735-95299

PATIENT INFORMATION:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Health Plan: _____

Today's Date: _____
Date of Birth: _____
Home Phone: () _____
Work Phone: () _____
Department or Extension: _____

DRUG ALLERGIES:

MEDICAL PROBLEMS:

1. _____
2. _____
3. _____
4. _____
5. _____

6. _____
7. _____
8. _____
9. _____
10. _____

VACCINATIONS (Please give date when last given)

Tetanus: _____
Pneumovax: _____
Measles/Mumps/Rubella: _____
HIB(Meningitis titer): _____
Whooping Cough: _____
Typhoid: _____

Flu Vaccine: _____
T.B.: _____
Oral Polio: _____
Hepatitis B: _____
Diphtheria: _____
Small Pox: _____

RISK FACTORS: Cigarettes: Yes/No _____ per day/week

Alcohol: Yes/No _____ per day/week

WOMEN ONLY:

Last Papsmear: _____ Last Mammogram: _____ Contraceptive: _____
Total Pregnancies: _____ Total live births: _____ Miscarriages/Abortions: _____

MEDICATIONS: (Please list directions)

1. _____
2. _____
3. _____
4. _____
5. _____

6. _____
7. _____
8. _____
9. _____
10. _____

* THANK YOU! *

PATIENT HISTORY

NAME _____ AGE _____ SEX _____ TODAY'S DATE _____

Please list all current symptoms _____

Have you ever had any blood transfusions, and if so when: _____

FAMILY HISTORY: if a blood relative had the following, please state which relative:

Tuberculosis _____	Diabetes _____	Heart attack _____
Stroke _____	Cancer _____	Kidney disease _____
Migraine _____	Allergy _____	Glaucoma _____
Mental illness _____	Arthritis _____	Hypertension _____
Epilepsy _____	Gout _____	

MEDICAL HISTORY: have you had any of the following, if so please indicate your age at the time of illness:

Hearing Loss _____	Leg pain _____	Hand tremors _____
Ringing in ears _____	Varicose veins _____	Numbness _____
Ear infections _____	Problems swallowing _____	Tingling _____
Dizziness _____	Heartburn _____	Frequent headaches _____
Vision Loss _____	Persistent nausea _____	Bruising easily _____
Eye pain _____	Peptic ulcer _____	Bone fracture _____
Eye infections _____	Abdominal pain _____	Rashes _____
Sinus Trouble _____	Diarrhea _____	Trouble Sleeping _____
Freq. sore throats _____	Constipation _____	Nervousness _____
Hayfever _____	Bloody stool _____	Depression _____
Bronchitis _____	Hemorrhoids _____	Memory loss _____
Chest Pain _____	Hernia _____	Mental illness _____
High Blood Pressure _____	Frequent urination _____	Chronic fatigue _____
Heart Murmur _____	Blood in urine _____	Mumps _____
Palpitations _____	Kidney stones _____	Polio _____
Gout _____	Venereal disease _____	Measles _____
Foot pain _____	Cancer _____	Tuberculosis _____
Numb feet _____	Diabetes _____	Chicken pox _____
Stroke _____	Thyroid disease _____	

ANY OTHER MEDICAL PROBLEMS: _____

Have you recently had any of the following: weight loss or gain, changes in appetite or changes in bowel habits? _____ If so, please explain: _____

List all medications you are presently taking: _____

List all allergies to any medications: _____

List any major surgical operations you have had: _____

List any other hospitalizations: _____

Social Habits: If any of these apply to you, please indicate amount:

Cigarettes _____ per day/week; Alcohol _____ Oz. per day/week; Coffee/tea _____ cups per day/week

Drugs: Indicate type and frequency _____

Exercise: Indicate type and frequency _____

Sleep: Indicate how well and average hours per night _____

CORONA FAMILY CARE

PATIENTS RIGHTS AND RESPONSIBILITIES

To comply with new federal regulations (HIPAA), this office has established procedure to make your identify and medical records more secure. Our only use of your personal information is for billing purposes and for proper medical treatment. We must have on record a signed acknowledgement, that you have read your rights and responsibilities as patients and that you understand them. Please contact the office staff if you have any questions.

PATIENTS RIGHTS

- ❖ To receive service within a reasonable period.
- ❖ To receive medically necessary services.
- ❖ To be treated with respect and courtesy.
- ❖ To receive all available information about your care and treatment, including risk and options.
- ❖ To have your medical coverage explained to you.
- ❖ To have all medical and personal records treated as confidential.
- ❖ To participate in treatment decisions.
- ❖ To refuse treatment.
- ❖ To receive impartial access to treatment.
- ❖ To receive a second opinion regarding any treatment plan.
- ❖ To review or to receive a copy of your medical record subject to legal restrictions and reasonable copying charges.
- ❖ To request review of your medical record by the physician and to request corrections if necessary.
- ❖ To be given information on how to file a complaint/grievance.
- ❖ To formulate an advance directive if you have a life threatening illness or injury.
- ❖ To provide or have provided for you, an interpreter in your primary language.

PATIENTS RESPONSIBILITIES

- ❖ Having the appropriate identification, insurance membership cards, coverage stickers, etc, at the time of the appointment.
- ❖ Keeping appointments or contacting this office in advance to cancel an appointment.
- ❖ Fulfilling financial obligations at the time of service such as deductible or co-pay fees.
- ❖ Providing complete and accurate information.
- ❖ Following the health plan you and the physician agree on.
- ❖ Being considerate of others.
- ❖ Providing legal documentations of guardianship of a minor being treated.
- ❖ Providing a list of persons who may receive medical information about you, on your behalf, in an emergency.

Please sign and return this form to the front desk.

Signature _____

Date _____

COMMUNICATION CONSENT AGREEMENT

I UNDERSTAND THAT UNDER FEDERAL LAW (HIPAA), THIS MEDICAL OFFICE MAY **NOT** RELEASE ANY MEDICAL INFORMATION TO ANY INDIVIDUAL, WITHOUT MY EXPRESS WRITTEN PERMISSION. LAW ENFORCEMENT AND COURT ORDER ARE TWO EXCEPTIONS TO THIS REQUIREMENT. I, THEREFORE, **GIVE** PERMISSION TO THIS OFFICE TO RELEASE MEDICAL INFORMATION ON MY BEHALF, TO THE FOLLOWING PERSON(S):

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____

PHONE #: _____ AGE: _____ BIRTHDATE: _____

DRIVERS LICENSE # _____ SOCIAL SECURITY # _____

OTHER FORMS OF IDENTIFICATION: _____

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____

PHONE #: _____ AGE: _____ BIRTHDATE: _____

DRIVERS LICENSE # _____ SOCIAL SECURITY # _____

OTHER FORMS OF IDENTIFICATION: _____

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____

PHONE #: _____ AGE: _____ BIRTHDATE: _____

DRIVERS LICENSE # _____ SOCIAL SECURITY # _____

OTHER FORMS OF IDENTIFICATION: _____

PATIENT SIGNATURE: _____ DATE _____

CORONA FAMILY CARE, INC.

Jeffery A. Muller, M.D.

Anthony Pinner PA-C

341 Magnolia Ave. Suite. 201

Corona, CA 92879

Phone (951) 735-9211

CONSENT AND FINANCIAL RESPONSIBILITY

I hereby consent to medical treatment by Jeffery A. Muller, M.D., Anthony Pinner, PA-C

_____ Initials

I understand that all fees are due at the time of service unless Jeffery A. Muller, M.D. and/or Anthony Pinner, PA-C, are contract provider for my insurance plan in which case all co-pays, deductible, and/or patient percentage requires by my insurance are due at the time of service. I understand that my medical insurance may not pay fully for my medical bill and I accept full financial responsibility for all charges that I incur in Jeffery A. Muller, M.D. and Anthony Pinner, PA-C, care. I understand that any banking or return check fees will be my responsibility. Return check fees are \$35.00 per return.

_____ Initials

I understand that I will receive a monthly billing statement for any balance for which I am responsible and that if I fail to pay the "Due From Patient" portion in full by the due date, I will be charged 1.5% interest per month on the unpaid balance.

_____ Initials

Signature

Date

If you wish to have our office bill your insurance company for your incurred charges, you must sign the Assignment of Benefits and Release below. This assignment is assumed to apply to all future claims unless you notify us in writing to the contrary.

I hereby authorize my insurance benefits to be paid directly to Jeffery A. Muller, M.D. and Anthony Pinner, PA-C, and I accept financial responsibility for any non-covered services. I authorize to release Jeffery A. Muller, M.D. and Anthony Pinner, PA-C, any information required to process insurance claim made on my behalf.

Signature

Date

If you are signing this agreement as the responsible party for a minor child, please fill out the statement below as indicated.

I, _____, _____, accept full
(Your Name) (Relationship to Patient)

Financial responsibility as described above and consents to medical treatment by Jeffery A. Muller, M.D. and Anthony Pinner, PA-C for _____, a minor.

(Child's Name)

NOTICE OF PRIVACY PRACTICES

(MEDICAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing, or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of _____, 20____ and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA
or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

CORONA FAMILY CARE, INC.

Jeffery A. Muller, M.D., Anthony Pinner, PA-C,

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessment and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this *Notice of Privacy Practices Acknowledgement*, but was unable to do so as documented below:

Date:	Initial:	Reason:
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CORONA FAMILY CARE, INC.

Jeffery A. Muller, M.D., M.D., Anthony Pinner, PA-C,

A MESSAGE TO OUR PATIENTS ABOUT ARBRITRATION

Our Mal- Practice Insurance Carrier has asked that our patients sign the attached Arbitration agreement. Listed below are the reasons for the arbitration agreement, if you have a question please feel free to discuss with your physician.

By signing this agreement we are agreeing that any dispute arising out of medical services you receive is to be resolved in binding arbitration rather than a suit in court. Lawsuits are something that no one anticipated and everyone hopes to avoid. We believe that the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between health care providers and their patients have long been recognized and approved by the California Courts.

By signing this agreement you are changing the place where your claim will be presented. You may still call witnesses and evidence. Each party selects an arbitrator (party arbitrators), who then select a third, neutral arbitrator. These three arbitrators hear the case. This agreement generally helps to limit the legal costs for both patients and physicians. Further, both parties are spared some of the rigors of trial and the publicity that may accompany judicial proceedings.

Our goal, of course, is to provide medical care in such a way as to avoid any such dispute. We know that most problems begin with communication. Therefore, if you have any question about your care please feel free to ask us. Thank you.

Sincerely,

Corona Family Care, Inc.

341 Magnolia Avenue Suite 201 Corona, CA 92879

Phone: (951) 735- 9211 Fax: (951) 735- 9299

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, negligently, or incompetently 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 rights 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 service provided by the physician including any spouse or 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 the 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: 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 days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. 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 of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

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 consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

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 Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute 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 arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services

Patient's or Patient Representative's Initials

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

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

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.

By: _____ (Date) _____
Physician's or Authorized Representative's Signature

Corona Family Care, Inc.
441 Magnolia Ave. # 201
Corona, CA 92630
Print or Stamp Name of Physician, Group, or Association Name
(951) 735-9211

By: _____ (Date) _____
Patient's or Patient Representative's Signature

By: _____
Print Patient's Name

(If Representative, Print Name and Relationship to Patient)