Akerman MED

Dr. Allan Akerman/ Dr. Stephanie Lao/ Dr. Jessica Barr
1310 W Stewart Dr Ste. 307, Orange, CA 92868
1220 Hemlock Way Ste. 200, Santa Ana, CA 92707
22 Odyssey Suite 200, Irvine, CA 92618

REGISTRATION FORM

Today's date:	Primary Care Physician:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Race:	Ethnicity:	Birth date: / /	Age:	Sex: ❑ Female ❑ Male ❑ Unspecified (X) ❑ Undisclosed (U)

Street address:	Apt #	Social Security no.:	Home phone no.: ( )

City:	State:	Zip Code:	Cell phone no: ( )

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ____________ ❑ Insurance Plan ❑ Hospital
❑ Family ❑ Friend ❑ Close to home/work ❑ Internet ❑ Other

e-mail (*for patient portal)*:

Pharmacy:	Address & City:	Phone no:

INSURANCE INFORMATION (PLEASE GIVE INSURANCE CARD TO FRONT DESK)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Employer:	Employer phone no:	If HMO plan, what medical group do you have? ❑ Optum- Monarch ❑St. Joseph Heritage ❑St. Joseph Affiliated Physicians

Please indicate primary insurance ❑ Aetna ❑ AnthemBlue Cross ❑ Blue Shield ❑ Cigna ❑ Health Net
❑ Tricare ❑ United Health Care ❑ Medicare ❑ Medi-Cal/CalOptima ❑ Oscar ❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Policy no.:	Group no..:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child	Co-payment $:

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Cell phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

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Medical History Form

Date: ________________

Name____ Age __________ Occupation ____

What is the reason for your visit today? You may not receive all services today, but it gives us a better idea of what you would like done.

- ☐ Clinical breast exam/Mammogram referral
- ☐ Pelvic exam
- ☐ Pap Smear
- ☐ STD screening
- ☐ IUD consultation
- ☐ Birth Control Consultation
- ☐ Pregnancy
- ☐ Irregular bleeding
- ☐ Other:

Contraception

Will this be your first pelvic exam? ☐ Yes ☐ No
Have you ever used birth control before? ☐ Yes ☐ No

Circle the types that you have used:

IUD	Patch/Ring	Natural Family Planning/Rhythm
Pills	Shot/Depo	Tubal/Vasectomy
Other	Abstinence	Suppository/Film/Foam
Implant	Withdrawal	Diaphragm/ Cervical Cal
Condoms	Emergency pill	

Any problems with them? ☐ Yes ☐ No
If yes, what problem(s)? __________________________
Current form of birth control? _____________________
How long? __________ Any problems with it? ☐ Yes ☐ No

Sexual History

Yes	No	
☐	☐	Have you ever had sexual intercourse? Age at first time? _______
☐	☐	Are you currently in a sexual relationship? Length of current relationship? ____
☐	☐	New sex partner in the last 60 days?
☐	☐	Partner with symptoms in the last 60 days?
☐	☐	Positive Chlamydia in the last 12 months?
☐	☐	Other sexually transmitted disease (STD) in the last 12 months?
☐	☐	Exposed to an STD in the past 60 days?
☐	☐	Did you use a condom with your last intercourse?

How many sexual partners have you had:
In the past 60 days? _____ past year? ______ last 10 years?______

☐	☐	Does your partner(s) have sex with someone other than you?

How do you protect yourself from STDs? _______________________

Menses

When was the first day of your most recent menstrual period? ____________
How many days does it usually last? __________
How old were you when your period started? __________

Yes	No	
☐	☐	Was your last period normal?
☐	☐	Do you have a period each month?
☐	☐	Are you concerned that you could be pregnant?
☐	☐	Do you have severe cramps with your period?
☐	☐	Do you bleed between periods?
☐	☐	Do you douche, use vaginal sprays, or powders? If yes, how often? _________________

Pregnancy

Are you currently trying to become pregnant? ☐ Yes ☐ No
Are you concerned about infertility? ☐ Yes ☐ No

☐ **Never been pregnant (skip the rest of this section)**

Age at first pregnancy ________ Last pregnancy _________
Are you currently breastfeeding? ☐ Yes ☐ No
# of Pregnancies ____________ # of live births ____________
# of miscarriages ___________ # of abortions______________
# of Ectopic (tubal) __________ # of living children __________
When you were pregnant, did you get diabetes? ☐ Yes ☐ No
Complications during pregnancy, delivery, or afterward?
☐ Yes ☐ No If yes, please list: ________________________
____

Social History

Our services are confidential; however, if you are under the age of 18 and share with us a history of sexual abuse or rape, we are required by law to report this to Child Protective Services. If you have questions about these laws, please ask.

Yes	No	
☐	☐	Do you smoke? If yes, how long and how many cigarettes each day? ___________________________
☐	☐	Do you drink alcohol? If yes, how often and how much? ___________________________
☐	☐	Do you or your partner use IV or other street drugs? If yes, what? ___________________________
☐	☐	Would you like to receive information on where to get help for quitting tobacco, or a drug or alcohol problem? _________
☐	☐	Is violence a threat in your personal relationship (s)? ___________________________

Yes No

☐ ☐ Have you ever been bullied (coerced) into having sex?

We can provide referrals to help with concerns about sexuality, sexual assault or rape. We can also help you if are in a situation where you feel you are or were sexually, physically, or emotionally abused. Do you have concerns regarding any of these issues? ☐ Yes ☐ No

Medical History

Are you allergic to any medications, latex, shellfish, or copper? Yes ☐ No ☐

If yes, what are you allergic to and what happened? ____________________

Do you take (or are you supposed to take) medicines, natural remedies, aspirin, or other drugs every day? Yes ☐ No ☐

If yes, please list them ____________________

Have you ever had surgery, been a patient in a hospital, or had a major illness? Yes ☐ No ☐

If yes, explain ____________________

Where else do you go for your healthcare needs? ____________________

Have you ever had the following immunizations? Hep B series Yes ☐ No ☐ Tetanus Yes ☐ No ☐ Rubella Yes ☐ No ☐

Have you ever had a Pap smear before? Yes ☐ No ☐ If yes, what is the date of you last Pap? ____________________

Have all you Pap smears been normal? Yes ☐ No ☐ If no, when, where, and what was done? ____________________

Have you been exposed to DES (a hormone given to your mother between 1940 and 1970)? Yes ☐ No ☐

Have you had a mammogram before? Yes ☐ No ☐ If yes, when and what were the results? ____________________

Do you have any symptoms of a genital infection? Yes ☐ No ☐

Discharge Bumps Burning Odor Pain with urination

Sores Stool or anal problems Itch Pain with sex Rash

Bleeding after sex Urgent or frequent urination Other ____________________

Have you ever had or do you currently have any of the following?

(If yes, please discuss this with the medical staff. Do not write anything just check the boxes)

Never	Past	Current		Never	Past	Current	
☐	☐	☐	Diabetes	☐	☐	☐	Anemia
☐	☐	☐	Seizures	☐	☐	☐	Problems with your kidneys or bladder
☐	☐	☐	Heart attack or stroke	☐	☐	☐	Bone disease or weak bones
☐	☐	☐	High blood pressure	☐	☐	☐	Cancer
☐	☐	☐	Depression	☐	☐	☐	Breast surgery or problems
☐	☐	☐	Migraines or bad headaches	☐	☐	☐	Pelvic infection treated in the hospital
☐	☐	☐	Blood clots in legs, lungs, or brain	☐	☐	☐	Uterine fibroids or ovarian cysts
☐	☐	☐	Hepatitis or gallbladder problem	☐	☐	☐	Eczema or bad skin rashes
☐	☐	☐	Blood transfusions or IV drug use	☐	☐	☐	Ectopic or tubal pregnancy
☐	☐	☐	Thyroid problems	☐	☐	☐	Respiratory problems
☐	☐	☐	Stomach or intestinal problems	☐	☐	☐	Hearing problems
☐	☐	☐	Any other serious medical condition, surgery, or hospitalization	☐	☐	☐	Vision problems (other than corrective lenses)

Family History

Are you adopted? ☐ Yes ☐ No If yes, please fill out the information below based on your biological family's information.

Has anyone in your IMMEDIATE family (mother, father, sister, brother, daughter, son, OR if your parents are less than 50, give information about your grandparents) had any of the following:

		Yes	No	
Cancer:	Who, what type, and at what age found?	☐	☐	____________________
Heart Attack:	Who and at what age?	☐	☐	____________________
Diabetes:	Who and at what age?	☐	☐	____________________
Stroke:	Who and at what age?	☐	☐	____________________
Blood clots:	Who and at what age?	☐	☐	____________________
High Blood Pressure:	Who and at what age?	☐	☐	____________________
High Cholesterol:	Who and at what age?	☐	☐	____________________

Patient Signature ____________________ Date ____________________

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Patient Name: ______________________________ D.O.B.__________________

Authorized Methods of Communication (check all that apply)

❑ RESIDENCE TELEPHONE	❑ CELLULAR PHONE	❑ WORK TELEPHONE	❑ WRITTEN CORRESPONDNCE
Number ( )	Number ( )	Number ( )	❑ Mail Service
❑ Leave call back number only; do not leave message	❑ Leave call back number only; do not leave message	❑ Leave call back number only; do not leave message	❑ Fax ( )
❑ Okay to leave detailed message with person	❑ Okay to leave detailed message with person	❑ Okay to leave detailed message with operator	❑ E-mail @ Residence:
❑ Okay to leave detailed message on voicemail	❑ Okay to leave detailed message on voicemail	❑ Okay to leave detailed message on voicemail	❑ e-mail @ work:

Other person we can disclose info to? *(If yes, please list name, phone no, and relationship)*

____

____

____

Patient signature:______________________________ Date: ______________________

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Financial Policy

To Our Patients:

Thank you for selecting our office for your medical care. We are committed to providing you with the best possible care. Your clear understanding concerning the responsibility for payment for medical services provided to our patients. The following information is provided.
The patient (or guarantor) is responsible for payment for services provided by a physician from our office at the time of service. We accept cash, checks, and credit cards only. The co-pays are expected at the time of service, we do not bill for them. However, should certain benefits not be covered by your plan, you will be responsible for payment for these services. If a balance becomes your responsibility, the amount is due in full within 30 days & if not paid it will be assigned to an outside collection agency. Out of area patients will be required to pay in full at the time of service. It is the patient's responsibility to know the services that are and that are not covered by their insurance.

HMO/PPO Contracted Insurance Coverage
If you have insurance coverage through a company that we are contracted with we require a copy of your insurance card and payment of your deductible and/or co-pay at the time of service. Failure to provide this information may require you to pay in full at the time of service. Please be prepared to pay your co-pay in full for each visit.

Medicare
Our physicians are participating Medicare providers. Office visits to a doctor are covered under part B of the Medicare program. Medicare pays 80% of their allowed charges after you pay your annual deductible per calendar year. If you have supplemental insurance we require a copy of your insurance card.

I have read all the information above and agree that regardless of my insurance status I am ultimately responsible for the balance on my account for any professional services rendered.
In the event my insurance company is billed, I authorize payment of medical benefits to be paid directly to Clinica Prenatal San Jose, Inc. for rendering services. A photo copy of this agreement shall be considered as effective and valid as the original.

Non-covered medical services are the responsibility of the patient.

If a check is returned from the bank for non-payment (i.e. nonsufficient funds, acct. closed, payment stopped, etc…), there will be a bank fee applied to my account in addition to the amount of the returned check. I will be required to pay in cash at the time of service for future visits.
In the event any lawsuit or action is brought to collect this account or any portion thereof, I agree to pay a reasonable sum for attorney's fee in addition to costs and disbursement provide by statue.

____ ______________________
Responsible Party's Signature Date

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Notice of Privacy Practices

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

Uses and Disclosures

Treatment- Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment- Your health information may be used to seek payment from your health plan or from other third party payers that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided and the medical condition being treated.

Health care operations- Your health information may be used as necessary to support the day-to-day activities and management of Clinica Prenatal San Jose.

Law Enforcement- Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting- Your health information may be disclosed to public health agencies required by law. For example, we are required to report certain communicable disease to the state's public health department.

Appointment Reminders- Your health information will be used by our staff to send you appointment reminders. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorizations. If you change your mind after authorizing a use or disclosure of our information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Individual Rights- You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition & treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Right to Revise Privacy Practices- As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice of any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Request to Inspect Protected Health Information- You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the front office receptionist: Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints- If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns. If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint. You also may file a complaint with Secretary of Health and Human Services.

Received and accepted: ____ Date: ________________________

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Dear Patient,

Every patient that we have an opportunity to care for is entitled to and will receive the best care that we can provide.

However, between medical seminars, meetings, and periodic vacations, it is humanly impossible for any physician to be available 24 hours a day, 365 days a year. We may not be available when you call. This does not mean that you will not receive the medical attention that you require.

When we are not available, another equally qualified doctor will provide medical care for you. These arrangements help assure us that you will be cared for by a physician who is able to function at peak efficiency.

The on-call physician will provide care for labor and delivery, gynecological problems, and emergency room visits.

In case of emergency, please call office phone number and the exchange will contact you with the on-call physician. If this is an emergency and your call is not returned immediately, proceed directly to the hospital or call 911. In cases of non-emergency calls, the on-call physician will call you back in a reasonable amount of time.

When calling the physician for a problem, please have the pharmacy phone number ready in case a medication needs to be prescribed.

If you have any questions, please do not hesitate to ask at the time of your visit.

Sincerely,

Allan Akerman, M.D.

I ACKNOWLEDGE RECEIPT OF THIS LETTER.

Patient signature: ____ Date:_________________________

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CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATION

I, ______________________ , hereby authorize Clinica Prenatal San Jose, Inc. to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign it, Dr. Akerman can refuse to treat me.

I have been informed that Clinica Prenatal San Jose, Inc. has prepared a Notice of Privacy Standards ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying my practitioner, in writing, but if I revoke my consent, such revocation will not affect any action that my practitioner took before receiving my revocation.

I understand that Clinica Prenatal San Jose, Inc. has reserved the right to change their privacy practices and that I can obtain such change notice upon request.

I understand that I have the right to request that Clinica Prenatal San Jose, Inc., restricts how my individual identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that Clinica Prenatal San Jose, Inc. does not have to agree to such restrictions, but that once such restrictions are agreed to, they must adhere to such restriction.

____

Signature of patient or patient's representative Date

____

Print Name of patient

____

Relationship to the patient

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NO SHOW/CANCELLATION POLICY

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Clinica Prenatal San Jose reserves the right to charge a fee of $50.00 for all missed appointments (“no shows”) and appointments that are not cancelled or rescheduled with a 24-hour advance notice.

“No show” fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple “no shows” in any 12 month period may result in termination from our practice.

Thank you for understanding and cooperation as we strive to best serve the needs of all of our patients.

Patient Name ____

Signature ____

Date ______________________

Social Media Consent

AkermanMed would like your permission to use images taken of you/your child on our Facebook and Instagram pages.

☐ Yes, I grant permission to AkermanMed to post photos of me/my child on the social media accounts indicated above.

☐ No, I don't grant permission to AkermanMed to post photos of me/my child on the social media accounts indicated above.

Patient Name: ______________________________________

Date of birth: _______________________________________

Patient Signature: ___________________________________