Health and Wellness Center

Lake Forest Office:
23672 Birtcher Dr.
Lake Forest, Ca 92630

San Clemente Office:
665 Camino De Los Mares Ste.203
San Clemente, Ca 92673

PATIENT INFORMATION Today's Date: _____

Last Name: _____ First Name: _____ Middle: _____
Street Address: _____ Apt. _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Other Phone: _____ Sex: F M
Date of Birth: _____ Age: _____ Marital Status: Sgl Mar Div Wid
Soc. Sec. No: _____ Drivers License: _____
Name of Parent or Guardian_____
Email Address:_____
Language Spoken: __English__Spanish__Chinese__Vietnemese__Farsi__Other__(mu)
Ethnicity:__White__Asian__African American__Mexican__Latin American__Other__(mu)
Patient Declined to Specify Race :__(mu)
How do you want us to contact you: address:__Home No:__Cell No:__Email:__(mu)
Patient Declines all Reminders :__(mu)

EMPLOYMENT INFORMATION

Employer Name: _____ Occupation: _____
Address: _____ How Long: _____
City: _____ State: _____ Zip: _____
Telephone: _____

MEDICAL INSURANCE INFORMATION

Primary Insurance Carrier:
Address: _____
City/State/Zip: _____
Subscriber: _____
Relationship: _____
Soc. Sec.#: _____
Group #: _____

Secondary Insurance Carrier:
Address: _____
City/State/Zip: _____
Subscriber: _____
Relationship: _____
Soc. Sec. #: _____
Group #: _____

IN CASE OF EMERGENCY CONTACT

Name: _____ Relationship: _____
Address:_____ City: _____ State: _____
Phone: _____

ASSIGNMENT OF BENEFITS

I authorize release of any medical information necessary to process entitled to the
Insurance claims on my behalf. I authorize payment of medical benefits minor, do
Directly to the doctor for service provided to me. A copy of this
Authorization shall be considered as valid as this original.

Signature: _____

CONSENT TO TREATMENT OF MINOR

I (we) being the parent(s) or Guardian(s),

care, custody and control of the aforesaid

hereby authorize and direct you to render such Treatment to said minors as in your judgment is advisable.

Signature: _____

HEALTH AND WELLNESS CENTER POLICIES

We would like to thank you for choosing Health and Wellness Center as your medical provider. We have written this policy to keep you informed of our current office policies.

Office Hours: **Our Lake Forest office is open: (949)770-7301**
Monday-Friday, 8:00am-5:00pm

Our San Clemente office is open: (949)493-9344
Monday, Tuesday, and Thursday, 9:00am-5:00pm
Wednesdays and Fridays, 9:00am-1:00pm

APPOINTMENTS: We see patients by appointment only. Same day appointments are usually available for urgent or sudden illness.
AFTER HOURS AND EMERGENCIES: For a serious emergency call 911 right away. If you are not sure and you call our office, please be sure to tell the person who answers the phone it is an emergency. After hours you will reach our voice mail which will instruct you on how to contact one of our providers.
URGENT NEED OR SUDDEN ILLNESS: We will refer you to urgent care. It is your responsibility to make sure it is covered by your insurance.
CANCELATIONS: Please call within 24 hours if you are unable to keep your scheduled appointments. This allows us to provide that time slot to another patient. There is a **$50.00** fee for missed appointments.
TREATMENT OF MINORS: Patients under the age of 18 must be accompanied by a parent or guardian, or have written permission for treatment, from a parent or guardian.
LAB WORK: If lab work is ordered, you will be referred to a lab based on your insurance. For cash patient's it is your responsibility to look for low cost laboratory. If unable to find a low cost lab we will refer you to Quest Diagnostics.
COMPLETE PHYSICAL EXAMS: We believe that routine, annual complete physical exams with screening lab tests are very important to the maintenance of good health. However, insurance benefits vary. Some policies cover "wellness" and others cover visits when you have a complaint. Please verify your insurance benefits prior to your appointment to determine what is covered by your insurance plan.
TEST RESULTS: If you have diagnostic testing, i.e, lab, x-ray, echo, ultrasound, sleep study, please schedule a follow-up appointment, within 7-10days, to go over the results with your physician. There will be a copay/coinsurance. Results will not be given over the phone.
PRESCRIPTION AND REFILLS:
The best time to get a prescription refill is at your appointment. If you need to call for refill, don't wait until you have run out. Most refills require the doctor's approval. Contact your pharmacy and have them fax to us a "refill request". We ask that you give us 5 working days for prescription to be called in. Call them first to see if it is ready. Some medications have potential side effects that must be monitored. We require check-ups every 1 or 4 months depending on medications. Be sure to keep those follow-up appointments. Some prescriptions cannot be called in. The prescription must be printed

for you to pick up. Don't call after hours for prescription refills. There is no access to your chart and we may not be able to help you.

SAMPLES: We sometimes offer you samples to help you try out a new medication before you purchase it. Remember that samples are not a long term way to fill your prescription. We do not always have samples of your medications. Please do not rely on samples for medications you take long term.

MAIL ORDER PRESCIPTIONS: Many insurance plans offer financial incentives for using mail order pharmacies. We are glad to print out prescriptions for your mail order pharmacy needs. You can pick these up at our office.

REFERRALS: Sometimes this can be done on the same day as your appointment and sometimes it can take several days, depending on your insurance and/or the urgency of your situation. Someone will contact you as soon as the referral authorization is obtained. It is your responsibility to ensure your specialist receives your test results. Please understand that it can sometimes take a few weeks to get an appointment with a specialist. This is not something we have control over.

A COPY OF THIS FORM WILL BE PROVIDED AT YOUR REQUEST. PLEASE INFORM THE RECEPTIONIST.

Health and Wellness Center Associates Financial Policies.

No Insurance: Payment will be due at the time of service. If you are unable to pay your balance in full, you will need to make prior arrangements with our Accounts Manager or Customer Service Representative. The initial consultation will cost $150.00 and each follow up appointment will be $125.00.

Insurance: Although we are contracted most insurance companies, it is your responsibility to make sure that our physician is in your plan. It is also your responsibility to know your insurance benefits. We will need all your demographic and insurance information prior to your appointment. We will also request an update on this information approximately every six months. We ask that at the time of your appointment you bring your insurance card and photo ID as well as any other forms that will assist in making sure that your claim is filed correctly. At the time of service you will be responsible for all fees that are not covered by your insurance, including co-pays, co-insurance, deductibles and non-covered services or items received. The co-pay cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier. We strive to be as accurate as possible in calculating your responsibility but, with so many variations in policies and fee schedules, we are not always exact. You may receive a statement from our office for any balance due. For your convenience we accept cash, checks, credit cards (Visa, MasterCard, American Express and Discover).

RETURN CHECK: Will be subject to non-sufficient fund fee, depending on bank.

AUTO ACCIDENT: If your injury is a result to an auto accident, you are required to pay for services and then collect from the auto carrier. We will not file your insurance but will provide you with a receipt to do so.

WORKER COMPENSATION: If your injury is due to an accident in your work place, please inform the receptionist immediately. We are not authorized to treat you for this type of claim. We regret any inconvenience this may cause.

DISABLITY, INSURANCE FORMS, ATTENDING PHYSICIAN STATEMENTS: There will be a charge of $10.00-$125.00 for the completion of medical forms or you may be required to schedule an appointment. Payment is due at the time that you pick-up these forms. Please allow 7-10days for the completion of these forms. If you would like the forms mailed to you or the insurance, payment will be due prior to mailing. FMLA forms require that you come in for an appointment.

MEDICAL RECORDS: We will provide you a copy of your medical records upon request and for a fee. You will need to sign release consent prior to having them copied. Please allow up to 30days for this request to be processed.

BILLING: If you receive a bill from us, and have any questions, please call our billing department immediately. If you cannot pay your entire balance, please call to make payment arrangements.

COLLECTIONS: Accounts that are not paid within 30 days will begin our in house collection process. If your balance becomes 65 days old, your doctor will be notified and you may be subject to dismissal from the practice.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT: HIPAA requires that entities take the appropriate standards to protect the privacy of patient information. HIPAA's Privacy Rule provides that all information that can be used to identify a patient is "Protected Health Information." Furthermore, all PHI must only be used and transmitted to service the patient's physical or mental health, provide health care to that individual, and to submit and process the payment of the individual's health care services.

ACKNOWLEDGEMENT:

I acknowledge that I have received and read a copy of the Health and Wellness Center Office and Financial Policies.

_____, _____

Patient Signature/Parent or Guardian, **Date**

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 or patient to collect or contest any medical fee shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any malpractice claim, 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: _____ _____
Physician's or Authorized Representative's Signature (Date)

_____
Print or Stamp Name of Physician, Medical Group, or Association Name

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

By: _____
Print Patient's Name

_____
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.
(2-12)

Health and Wellness Center

Lake Forest Office:
23672 Birtcher Dr.
Lake Forest, Ca 92630

San Clemente Office:
665 Camino De Los Mares
Suite 203
San Clemente, Ca 92673

Patient Name: _____

Date: _____

Selling Nutritional and Herbal Supplements

According the Federal Food, Drug, and Cosmetic Act, as amended, Section 201(g)(1), the term drug is defined as an "article intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease." Technically, vitamins, minerals, trace elements, amino acids, herbs, or homeopathic remedies are not classified as drugs. However, these substances can have significant effects on physiology and must be used rationally. In this office, we provide nutritional counseling and make individualized recommendations regarding use of these substances in order to upgrade the quality of foods in a patient's diet and to supply nutrition to support the physiological and biomechanical processes of the human body. Although these products may also be suggested with a specific therapeutic purpose in mind, their use is chiefly designed to support given aspects of metabolic function. Use of nutritional supplements may be safely recommended for patients already using pharmaceutical medications (drugs), but some potentially harmful interactions may occur. For this reason, it is important to keep all your healthcare providers fully informed about all medications and nutritional supplements, herbs, or hormones you may be taking.

Sale of Nutritional Supplements

You are under no obligation to purchase nutritional supplements at our clinics.

As a service to you, we make nutritional supplements available in our office. We purchase these products only from manufacturers who have gained our confidence through considerable research and experience. We determine quality by considering:

1. the quality of science behind the product
2. the quality of the ingredients themselves
3. the quality of the manufacturing process
4. the synergism among product components.

The brands of supplements that we carry in our facility are those that meet our high standards and tend to produce predictable results.

Supplements are not covered by health insurance. While these supplements may come at a higher financial cost than those found on the shelves of pharmacies or health food stores, the value must also include assurance of their purity, quality, bioavailability (ability to be properly absorbed and utilized by the body), and effectiveness. The chief reason we make these products available is to ensure quality. You are not guaranteed the same level of quality when you purchase your supplements from the general marketplace. We are not suggesting that such products have no value; however, given the lack of stringent testing requirements for dietary supplements, product quality varies widely.

If you have concerns about this issue, please discuss them with our staff.

I, _____, have read the above statements, understand them fully,
Patient Name
agree with them, and will comply with them.

_____ _____
Patient Signature Date

_____ _____
Attending Physician or MA Date

HEALTH AND WELLNESS CENTER, INC.

26372 Birtcher Dr. Unit A, Lake Forest, CA 92630
Phone: (949)770-7301 Fax: (9490770-0634

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:_____ Date of Birth:_____

Previous Name:_____ Social Security #:_____

I request and authorize MOHAMMED M. ALI_____ to release health care information of the patient named above to:

Name: _____

Address:_____

City:_____ State:_____ Zip Code:_____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates:_____

_____

☐ All health care information

☐ Other:_____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes Herpes, Herpes Simplex, Human Papilloma Virus, Genital Warts, Condyloma, Chlamydia, non-specific Urethritis, Syphilis, VDRL, Chancroid, Lymphogranuloma Venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and Gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient signature:_____ Date signed:_____

THIS AUTHORIZATION EXPIRES 1 YEAR AFTER IT IS SIGNED

ADVANCE MEDICAL DIRECTIVES

Definition
Advance Directives can protect your right to refuse or accept medical care if you ever become mentally or physically unable to choose or communicate your wishes due to an illness or injury.

Why have an "Advance Directive"?
This protects your right to make medical decisions that can affect your life. It helps your family by allowing them to avoid the responsibility and stress of making difficult decisions. It helps your doctor by giving them guidelines for your care.

What kind of situation might cause me to need an "Advance Directive"?
IF YOU EVER:
1. Have irreversible **brain damage or brain disease,** which can affect your ability to think as well as communicate.
2. Have a **permanent coma or other unconscious state**, which can leave you without hope of recovery.
3. Have a **terminal illness** in which you are expected to die within a short period of time.

What kinds of things can "Advance Directives" discuss?
1. **CPR**- A procedure is used to restore stopped breathing or heartbeat.
2. **IV Therapy (Intravenous)** – This is used to provide food, water, and/or medications through a tube placed in a vein
3. **Feeding tubes** – Are inserted through the nose, throat or through a hole in the abdomen (stomach wall) to provide liquid food/nutrition when you cannot eat, chew or swallow yourself.
4. **Respirators** – are machines used to keep a patient breathing when they are unable to breath on their own (previously called "iron lungs").
5. **Dialysis** – a method of cleansing the blood by a machine when kidneys are no longer working properly.

Advance Directives allow you to state whether you choose any of these procedures or wish to refuse them.

How do I get an "Advance Directive"?
You can make a "living will" or a durable power of attorney for health care. You can contact a lawyer to get one of these forms, or you can simply put your wishes in writing; be as specific as possible, then sign the document and have it witnessed and notarized.

Give a copy of your advance directive to your doctor as part of your medical records, and inform your family that you have done so. You can also make special requests or statements such as regarding organ donation, etc.

Where can I get more information or help in preparing "Advance Directive"?
- **Any family lawyer or attorney**
- **The state Attorney General's office**
- **The Internet** @ http://www.echonyc.com/choice
- **Local hospitals**
- **Local hospice agencies**
- **Local home health agencies**
- **Long term care facilities, such as local nursing homes**

Please **PRINT** your name:_____
(acknowledging that you have read the above)

Please **SIGN** your name:_____ Date:_____

Health & Wellness Center, Inc 23672 Birtcher Dr. Unit #A, Lake Forest, CA 92630

REQUIRED PATIENT INFORMATION FOR INSURANCE BILLING

(PATIENT)

LAST NAME: _____FIRST:_____ MI: _____DOB:_____/_____/_____ SEX: M _____F_____

STREET: _____APT #:_____CITY: _____ST:_____ZIP:_____

SS# _____H. PHONE: _____/_____WK PHONE: _____/_____ CELL PHONE: _____/_____

MARRIED: ___ SINGLE: ___ DIV: ___ OTHER: ___ SPOUSE'S NAME_____SPOUSE'S WK PH #_____/_____

SPOUSE'S CELL PH # _____/_____ EMAIL ADDRESS: _____REFERRED TO THIS OFFICE BY: _____

_____ EMERGENCY CONTACT NOT LIVING WITH YOU: _____PH #: _____/_____

PRIMARY INSURANCE INFORMATION

(INSURED)

(IF PRIMARY INSURED IS NOT THE PATIENT, LIST SPOUSE, PARENT OR OTHER INFORMATION OF PRIMARY INSURED BELOW)

INSURED NAME: _____DOB: _____/_____/_____SS# _____ SEX: M_____F_____

INSURANCE CO: _____ID#_____ GROUP #_____

PATIENT'S RELATIONSHIP TO INSURED_____

(Please include the social security number and date of birth of the primary insured for your insurance to be billed.)

SECONDARY INSURANCE INFORMATION

(INSURED)

(IF SECONDARY INSURED IS NOT THE PATIENT, LIST SPOUSE, PARENT OR OTHER INFORMATION OF SECONDARY INSURED BELOW)

INSURED NAME: _____DOB: _____/_____/_____SS# _____ SEX: M_____F_____

INSURANCE CO: _____ ID#_____ GROUP #_____

PATIENT'S RELATIONSHIP TO INSURED_____

PAYMENT POLICIES

You are responsible for anything your insurance does not cover. All Co-Pays are due and payable at each visit. These fees may apply:

- ☐ **$5 FEE FOR CO-PAYS NOT PAID AT TIME OF SERVICE.**
- ☐ **$50 NO SHOW FEE FOR ANY MISSED APPOINTMENT THAT WAS NOT CANCELLED OR RESCHEDULED 24 HOURS PRIOR TO THE APPOINTMENT. PLEASE BE CONSIDERATE AND CALL AT LEAST 24 HOURS BEFORE YOUR APPOINTMENT IF YOU CANNOT COME IN.**
- ☐ **$35 NSF CHARGE FOR ANY RETURNED CHECK FROM THE BANK**

If you are a private pay patient without insurance, all charges are due at the time of visit. We do not send statement to private pay patients.

PRESCRIPTION POLICY

Please do not wait until your last pill to call for a refill. There is a 72 hour turn around for prescription refills. If you have not seen the Physician in six months, the prescription will be denied. Assignment of benefits are payable to the doctors.

PLEASE SIGN AND DATE THIS DOCUMENT SHOWING THAT YOU HAVE READ AND UNDERSTAND OUR POLICIES.

SIGNATURE _____DATE: _____

Revised 04-11-16