Joel A. Sach, M.D., Inc.
18425 Burbank Boulevard, Suite 500, Tarzana, CA 91356
Tel: 818 344-7224 Fax: 818 401-9892

Dear Patient:

Please print the attached forms in ***black ink*** and then complete with the requested information.

ATTENTION:

PLEASE *DO NOT* RETURN YOUR COMPLETED REGISTRATION FORMS TO US BEFORE YOUR APPOINTMENT.

WE PREFER THAT YOU BRING YOUR PAPERWORK WITH YOU ON THE DAY OF YOUR APPOINTMENT AND
PLEASE *DO NOT* STAPLE THE PAGES TOGETHER.

IF YOU HAVE ANY QUESTIONS, PLEASE DO NOT HESITATE TO CALL US.

THANK YOU

Joel A. Sach, M.D., Inc.

18425 Burbank Boulevard, Suite 500, Tarzana, CA 91356
Tel: 818 344-7224 Fax: 818 401-9892

Dear Patient:

Welcome to my practice.

Please print the attached forms and complete all the requested information.

Please note:
If you have been referred to my office for a *Screening Colonoscopy* and you do not have any symptoms, please call your insurance company to see if this is a covered benefit of your policy. We may require you to sign an *Advance Beneficiary Notice* that states you are aware that the cost of your procedure may not be reimbursed by your insurance and that you will be financially responsible for payment.

Medicare patients please note:
Medicare will pay for a *Screening Colonoscopy* once every 10 years. However, you cannot have had a *Flexible-Sigmoidoscopy* within the last 4 years otherwise Medicare will deny payment. If you cannot remember, or if *you do know* that you have had a *Flexible-Sigmoidoscopy* within the last 4 years, then we will require that you sign an ***Advance Beneficiary Notice***. It will state that you are aware Medicare will not pay for the procedure and that you will be financially responsible for payment.

Below is a check list of all enclosed forms:

☐ **Patient information:**
Please do not forget to bring your insurance cards and the ID of the subscriber if it is not on the card.

☐ **Patient Medical History**

☐ **Ano-Rectal Health Questionnaire**

☐ **Payment Policy**: For new patients only – if you have not met your annual deductible, you will be required to make a payment on the day of your appointment. For your convenience we accept cash, checks Visa and MasterCard.

☐ **Privacy Policy:** Information regarding your Health Information Rights as dictated by the Federal Government.

I REALIZE THAT EVERYONE'S TIME IS VALUABLE AND I MAKE EVERY EFFORT TO SEE YOU AT YOUR APPOINTMENT TIME. PLEASE ASSIST US BY MAKING SURE YOU ARRIVE FOR YOUR APPOINTMENT ON TIME WITH YOUR PAPERWORK COMPLETED.

Joel A. Sach, M.D., Inc.

PATIENT INFORMATION FORM

IMPORTANT: PLEASE MAKE SURE YOU COMPLETE ALL ITEMS MARKED WITH AN ASTERISK.

*Your referring Doctor			Today's date		
* Patient's Last Name		First Name		Middle Initial	
* Address		City		State	Zip Code + 4
*Social Security #	*Birth Date	Age	*Marital Status ☐ **S** ☐ **M** ☐ **W** ☐ **D**	*Sex ☐ Male ☐ Female	
Driver's license #		* Home Phone		* Cell Phone	
Employer		Occupation		Work Phone	
*Local Pharmacy: Mail Order Pharmacy:		*Zip Code		*Telephone Number:	
Email Address:					
*Preferred Language Spoken:	*Ethnicity: ☐ Hispanic or Latino ☐ Non- Hispanic or Latino ☐ Declined to answer	*Race: ☐ American Indian / Alaskan Native ☐ Asian ☐ Black / African American ☐ Native Hawaiian ☐ Caucasian ☐ Pacific Islander ☐ Declined to answer			

<u>IMPORTANT:</u> UNLESS YOU AUTHORIZE US TO CONVEY YOUR MEDICAL INFORMATION, SUCH AS TEST RESULTS OR BILLING, TO A SPOUSE, RELATIVE OR FRIEND, WE WILL NOT RELEASE YOUR INFORMATION TO ANYONE OTHER THAN YOUR REFERRING DOCTOR.

<u>PLEASE INDICATE YOUR SELECTION BELOW:</u>

☐ NAME OF SPOUSE	☐ NAME OF RELATIVE
☐ NAME OF FRIEND	☐ MYSELF ONLY

PRIMARY INSURANCE :		
* Subscriber Last Name	First Name	Middle Initial
* Relationship to Patient	* Birth Date	* Insurance ID #
SECONDARY INSURANCE:		
***Subscriber Last Name	First Name	Middle Initial
* Relationship to Patient	* Birth Date	* Insurance ID #
PHARMACY INSURANCE:	PLAN NAME:	PLAN ID:

****

✶AT WHAT *CONFIDENTIAL* PHONE NUMBER DO YOU ALWAYS WANT TO BE CONTACTED?

☐ HOME ☐ CELL PHONE ☐ WORK ☐ OTHER

****

I HEREBY CONSENT TO AND AUTHORIZE ALL TREATMENT AND MEDICAL SERVICES PERFORMED BY DR. SACH & STAFF MEMBERS.

***Patient Signature** _____ ***Date** _____

_____

Parent Signature (if patient a minor**)**

PATIENT MEDICAL HISTORY

Last Name	First Name	Middle Initial	Today's Date

Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐ Long Term Partner ☐

Number of children:	Occupation:	
Do you smoke? YES ☐ NO ☐	How many years?	How many packs per day?
Do you drink alcohol? NO ☐ YES ☐ DAILY ☐ OCCASIONALLY ☐	How many years?	Glasses per day?

Do you drink tea, coffee or caffeine beverages? YES ☐ NO ☐	Cups/cans/glasses daily?	How many years?
Do you use cocaine or other drugs? YES ☐ NO ☐		

PAST HOSPITALIZATIONS

Reason for Admission	Hospital	Doctor	Date

ARE YOU ALLERGIC TO ANY DRUGS? YES ☐ NO ☐

IF ***YES***, PLEASE LIST THE DRUGS:

Please list your Current Medications, Vitamins, Herbs and Supplements, Include Dosage and How Taken.
If you need more room, please use a separate page:

Name: **Dosage:** **How Taken:**	**Name:** **Dosage:** **How Taken:**

Relation	State of Health	If Deceased, Cause ?	Age at Death
Father			
Mother			
Spouse			
Brothers			
Sisters			
Children			

FAMILY GASTROINTESTINAL HISTORY

Have any of your first degree relatives been diagnosed with a cancer of any of the following?

☐ ESOPHAGUS	☐ STOMACH	☐ COLON	☐ PANCREAS	☐ LIVER

☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Son ☐ Daughter

PERSONAL MEDICAL HISTORY

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING?

	YES	NO		YES	NO
CONSTITUTIONAL			**GENITOURINARY**		
Weight loss	☐	☐	**Bladder disease**	☐	☐
Fever, or chills	☐	☐	**Kidney disease**	☐	☐
Fatigue	☐	☐	**Kidney stones**	☐	☐
Faintness	☐	☐	**Prostate**	☐	☐
HEAD, EYES, EARS, NOSE			**HEMATOLOGICAL**		
Headache	☐	☐	**Anemia**	☐	☐
Vertigo	☐	☐	**Bleeding disorder**	☐	☐
Vision loss	☐	☐	**Clotting disorder**	☐	☐
Blurred vision	☐	☐	**IMMUNOLOGICAL**		
Glaucoma	☐	☐	**Immune Deficiency**	☐	☐
Double vision	☐	☐	**Other**	☐	☐
Hearing loss	☐	☐	**MUSCULOSKETAL**		
Ringing in the ears	☐	☐	**Arthritis**	☐	☐
Sinusitis	☐	☐	**Muscle pain**	☐	☐
CARDIOVASCULAR			**Joint pain**	☐	☐
Chest pain or pressure	☐	☐	**Back pain**	☐	☐
Heart murmur	☐	☐	**SKIN**		
Heart attack	☐	☐	**Skin rash**	☐	☐
Irregular heart beat	☐	☐	**Itching**	☐	☐
High or low blood pressure	☐	☐	**Pigmentation**	☐	☐
RESPIRATORY			**Loss of hair**	☐	☐
Cough	☐	☐	**NEUROLOGICAL**		
Shortness of breath	☐	☐	**Dizziness**	☐	☐
Asthma	☐	☐	**Numbness**	☐	☐
Bronchitis	☐	☐	**Stroke**	☐	☐
GASTROINTESTINAL			**Tremor**	☐	☐
Abdominal pain	☐	☐	**Weakness**	☐	☐
Diarrhea	☐	☐	**ONCOLOGICAL**		
Constipation	☐	☐	**Cancer of**	☐	☐
Blood in stool	☐	☐	**PSYCHOLOGICAL**		
Change in bowel habits	☐	☐	**Anxiety**	☐	☐
Heartburn	☐	☐	**Depression**	☐	☐
Cirrhosis	☐	☐	**Confusion**	☐	☐
Gallstones	☐	☐	**Memory loss**	☐	☐
Hepatitis	☐	☐	**ENDOCRINE**		
Hemorrhoids	☐	☐	**Diabetes**	☐	☐
Nausea	☐	☐	**Thyroid disease**	☐	☐
Reflux	☐	☐			
Vomiting	☐	☐	**Other:**	☐	☐

PATIENT SIGNATURE **DATE**

EXAMINING PHYSICIAN'S INITIALS _____ **DATE REVIEWED** _____

Anorectal Health Questionnaire

A Message from Doctor Sach to His Patients: Studies time have shown that during physician visits, patients are often too embarrassed to discuss important Anorectal Health/ Hemorrhoid Related issues. By filling out this questionnaire we hope to be able to break these barriers and to address important issues which may be affecting your overall health and well being.

Bowel & Dietary Habits
(Circle either Yes or No for each answer)

1. Do you suffer from Constipation? **Y / N**
2. Do you suffer from Diarrhea? **Y / N**
3. Do you have to strain or push hard when having a bowel movement? **Y / N**
4. Time spent on toilet during average bowel movement? _____Minutes
5. Does any tissue ever come out of your rectum (prolapse) during a bowel movement? **Y / N**
6. Do you often feel like you're "still not done" after a bowel movement? **Y / N**

Symptoms (in Rectal Area)
(Check all that apply)

☐ Bleeding	☐ Itching	☐ Prolapse	☐ Sensation of Incomplete Evacuation
☐ Pressure or Swelling	☐ Leaking or Soiling	☐ Pain	☐ Burning

Are You Interested in Learning About Painless, Non-surgical Treatment Options for Hemorrhoids? Y / N

Name_____

Date:_____

Patient Payment Policy

Thank you for choosing my medical practice. We are committed to providing you the best possible medical care. The following information is provided to avoid any confusion regarding payment for professional medical services. Our Insurance Billing Department will work with you to see that your claim is filed accurately and promptly.

Please sign below that you have read and agree to this Policy.

- **IT IS OUR PREFERENCE THAT YOU SETTLE ALL YOUR ACCOUNT BALANCES USING YOUR CREDIT CARD.**
  Your signature below authorizes Joel A. Sach, MD., Inc. to keep on file your credit card information so that all account balances may be charged to your credit card
- **All deductibles and co-payments will be collected *in full* at the time of service**
- If we are in-network with your insurance plan, we will ***not*** discount our services by any further amount after your insurance company has processed your claim and informed us of your responsibility.
- If we are not a contracted provider for your insurance company, we will bill them, as a courtesy, on your behalf.
- **PLEASE NOTE: Unpaid account balances will be assessed a $10.00 re-billing fee for <u>each</u> statement generated after 90 days have passed.**
- If your account is overdue for more than 120 days after your insurance has paid, it will be referred to a collection agency. This is done reluctantly, as a last resort, after we have exhausted all efforts for voluntary payment.
- **New Patients, and those who have no insurance, are required to pay at the time of service with either a credit card or cash. We do not accept personal checks.**

No Show Policy:

Please notify our office **24 hours in advance** if you are unable to keep your scheduled appointment. If you do not notify us and miss your appointment completely, we will require that you pay a ***<u>$50.00 missed appointment fee</u>*** before we will book you another office appointment.

In-Office Dispensing of Medications/Supplements:

For the purposes of patient convenience and efficiency, this office may offer in-office dispensing of medications and/or supplements from time to time. I hereby acknowledge that I have been informed that I may decline to purchase any such medications/supplements offered by Dr. Sach in the office and instead elect to purchase these medications/supplements at an outside pharmacy, whereby Dr. Sach will then provide me with a written prescription, if necessary.

Acknowledgement and Authorization

I have read, understand, and agree to abide by the above payment policy. I understand that charges not covered by my insurance company, as well as co-payments and deductibles, are my responsibility. **I authorize my insurance benefits to be paid directly to**: **JOEL A. SACH, M.D., INC.**

One - Time Authorization For Medicare recipients:

I request that payment of authorized Medicare benefits be made to me or on my behalf to Joel A. Sach MD., Inc. for any services furnished me. I authorize holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. Additionally, I request that payment of authorized Medi-Gap benefits be made to either me or on my behalf to Joel A. Sach MD., Inc. for any services furnished by this provider. I authorize any holder of medical information to release to my secondary insurance any information needed to determine these benefits or the benefits payable for related services.

SIGNATURE: _____ DATE_____

NOTICE OF PRIVACY POLICIES

As required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

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

PLEASE REVIEW IT CAREFULLY.

Introduction

Our practice is committed to treating and using your protected health information responsibly. This Notice of Health Information Practices describes the personal information we collect and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information as defined by federal regulations.

Understanding Your Health Record

Each time you visit our practice, a record is made of your visit. Typically, this record contains your symptoms, examination, test results, diagnoses, treatment, and a plan for future care or treatment. This information often referred to as your health or medical record serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- A source of data for medical research
- A source of information for public health charged with improving the health of this state and the nation
- A source of data for our business planning
- A tool with which we can assess and continually work to improve the care we render and outcomes we achieve.

Understanding what is in your record and how your health information is used, helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information. It will also allow you to make informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Joel A. Sach, MD., Inc the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request
- Inspect and copy your health record. You must submit your request in writing
- Amend your health record. Your request must be submitted and contain reasons to support your request.
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164..528
- Request communications of your health information by alternative means or at alternative locations
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164..522
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Joel A. Sach MD., Inc. is required to:

- By law, maintain the privacy of your health information
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us with or if you agree by email or fax.

We are permitted by law to disclose your health information for Treatment, Payment and Health Operations

For any other disclosure of your health information we are required to obtain your written authorization. **For example:** we would need your written authorization to give your health information to a healthcare insurance company that you apply to for health insurance coverage.

For More Information or to Report a Problem

If you have questions and would like additional information you may contact the practice's Privacy office, Susan Jacobs at 818 708 6070 ext 107

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or with the Office for Civil Rights. The OCR can be contacted at:
Office for Civil Rights, U.S. Dept of Health and Human Services, 200 Independence Ave., S.W., Room 509F HHH Building, Washington D.C. 20201

Examples of Disclosure for Treatment, Payment and Health Operations

We will use your health information for treatment

For Example: Information obtained by a nurse, physician or other member of our staff will be recorded in your medical record and used to determine your course of treatment. We will then provide your referring physician or a subsequent healthcare provider with copies of these reports that should assist him or her in treating you.

We will use your health information for regular health operations

For Example: Members of our medical staff, the risk or quality improvement manager may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare services we provide.

***Business Associates**:*

There are some services provided in our organization through contacts with business associates. Examples include our billing software vendor and the clearing house who handles the electronic transmission of our claims. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we have asked them to do. To protect your health information, however, our business associate is required to appropriately safeguard your information.

Notification:

We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition. We may also use and share with third parties your email address as well as other contact information as communication tools in attempt to keep you informed about up and coming information regarding products and services which in our opinion may be of interest and of potential benefit to you. If for any reason you would not like your contact information shared and would not like to receive any such information, you may simply opt out by contacting our communications director: Monica at (818) 344-7224 and ask to be removed from our mailing list.

Communication with family:

Health Professionals using their best judgment may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Appointment reminders:

We may disclose and use your health information to contact you to provide appointment reminders.

Food and Drug Administration (FDA):

We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or past marketing surveillance information to enable product recalls, repairs or replacement.

Worker's Compensation:

We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Public Health:

As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Law Enforcement:

We may disclose your health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney.

_____

MY SIGNATURE ACKNOWLEDGES RECEIPT OF THIS FORM DATE

Joel A. Sach, M.D., Inc.
18425 Burbank Boulevard, Suite 500, Tarzana, CA 91356
Tel: 818 344-7224 Fax: 818 401-9892

Patient Privacy Practices Preference Profile

Please read the following item(s) and select your preference, sign, and date.

My signature below confirms that I have:

1. ☐ Requested/Received a copy of the Revised Notice of Privacy Practices.
2. ☐ Prefer not to receive a copy of the Revised Notice of Privacy Practices.

1. ☐ Authorized the practice to retrieve my Medication History Data from the Surescrips database, if available, and import it into my Medical Record.
2. ☐ **NOT** authorized the practice to retrieve my Medication History Data from the Surescrips database, if available, and import it into my Medical Record.

1. ☐ Authorized the practice to share my medical, and demographic information with other ***healthcare providers*** to whom you may be referred.
2. ☐ **NOT** authorized the practice to share my medical, and demographic information with other ***healthcare providers*** to whom you may be referred.

Signature: _____ Date: _____

Print Name: _____