The Office of
Richard D. Brand, M.D.
2241 Wankel Way, Suite B • Oxnard, CA 93030
(805) 983-0425

Patient Information

Patient Information
(Please print)

Name _____

Address _____

City_____Zip _____

Home Phone ( ) _____

Cell Phone ( ) _____

E-mail Address _____

Birth Date _____ Sex ☐M ☐F

Marital Status ☐S ☐M ☐D ☐W

Social Security No._____/_____/_____

Employer _____

Occupation _____

Work Phone _____

Driver's License No. _____

Referred by _____

Medical Insurance Information *(Primary)*

Subscriber Name_____

Relationship to Patient _____

Insurance Co. _____

Policy No. _____

Group No. _____

Co-Payment _____

Responsible Party Information
(If other than patient)

Name _____

Address _____

City_____Zip _____

Relationship to Patient _____

Birth Date _____ Sex ☐M ☐F

Social Security No._____/_____/_____

Employer _____

Employer's Phone Number_____

Emergency Contact

1

Name _____

Relationship _____

Phone ( ) _____

Cell Phone ( ) _____

2

Name _____

Relationship _____

Phone ( ) _____

Cell Phone ( ) _____

Medical Insurance Information *(Secondary)*

Subscriber Name _____

Relationship to Patient _____

Insurance Co. _____

Policy No. _____

Group No. _____

Co-pay Amount _____

Authorization to Pay Benefits to Physician

I hereby authorize payment directly to Richard D. Brand, M.D. of surgical and/ or medical benefits, if any, payable for services rendered or supplies provided. I understand that I am responsible for paying any amount not covered by insurance.

Authorization for Medical Care and Treatment.

I hereby authorize the above name practice to provide medical care and treatment on my behalf.

Payment Terms

Cash payment or proof of insurance is required at time of service. Co-pay must be paid before seeing the doctor.

Signature _____ Date _____

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Prescription Medication Consent Form

The providers at Richard D. Brand, M.D., used an electronic medical record system that allows electronic prescribing of medications. Medications are sent to your pharmacy through a secured electronic prescription connection (***Dr. First***) which improves the timely and accurate transmission of your medication information.

To optimize the use of this electronic capability, and coordinate your care between us and your specialist, we ask that patients allow us to access their medication history through ***Dr. First***.

Please check only one of the following:

- ☐ I consent to allow my provider to access all of my medication history.
- ☐ I consent to allow my provider to access only my medication history for medications prescribed in this office.
- ☐ **I DO NOT** consent to my provider accessing any of my medications.

Signature: _____ Printed Name: _____

Date: _____

Formulario de Consentimiento de Medicamentos de Prescripción

Los proveedores de Richard D. Brand, M.D., utilizan un sistema electrónico de expedientes médicos que permite la prescripción electrónica de medicamentos. Las recetas médicas son enviadas a su farmacia a través de un medio seguro de prescripción electrónica (conocida en inglés como ***Dr. First***) el cual mejora la transmisión oportuna y precisa de la información de medicamentos.

Para lograr el uso óptimo de este sistema electrónico y coordinar la atención médica entre nosotros y su especialista, le pedimos a usted como paciente que nos permita acceder a su historial de medicinas recetadas por medio de ***Dr. First***.

Por favor marque sólo una de las siguientes opciones:

- ☐ Y permito a mi proveedor el acceso a todo mi historial de medicamentos recetados.
- ☐ Yo permito a mi proveedor tener acceso solamente a mi historial de medicamentos recetados en esta oficina
- ☐ **NO CONSIENTO** en que mi proveedor tenga acceso alguno a mi historial de medicamentos.

Firma: _____ Nombre en letra de molde: _____

Fecha: _____

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Release of Medical or Financial Information

Due to State and Federal policy relating to privacy it is necessary to have written permission to discuss any personal medical or financial information such as medication, laboratory, radiology, diagnosis and prognosis with anyone other than yourself such as husbands, wives, children, or other relatives or friends.

Please list below any person(s) to whom you will allow us to release any medical or financial information. If no one is listed then we will only discuss your medical and financial information with you. Information will still be provided to other health care providers, hospitals, or your insurance companies for the purpose of authorizations or other treatment or specialty referrals. Information to any other entity will need your separate signature specifically authorizing them to access your records.

I hereby authorized you to release my medical or financial information to the following:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

If you have additional names please list them on the back of this notice.

Patient's name _____ Signature _____

Date of birth _____ Today's Date _____

Liberación de Información Médica o Financiera

Debido a políticas de privacidad Estatales y Federales, es necesario que usted nos de autorización por escrito antes de proporcionar cualquier información médica o financiera, tales como medicamentos, servicios de laboratorio, radiología, diagnosis y prognosis a sus familiares o amigos

Por favor escriba abajo los nombres de las personas a quienes usted da autorización para obtener información de su expediente médico. Si no da el nombre de alguna persona, solo podremos hablar con usted sobre su expediente médico. La información de su expediente médico continuará a disposición de otras clínicas, hospitales, y compañías de seguro médico para fines de autorización de tratamientos médicos u otras referencias de tratamiento o especialidad. Para proporcionar información de su expediente a cualquier otra entidad se requerirá de su firma por separado.

Yo, por la presente, doy autorización de obtener información de mi expediente médico a las personas nombradas abajo:

Nombre _____ Relación _____

Nombre _____ Relación _____

Nombre _____ Relación _____

Si tiene nombres adicionales favor de enlistarlos al reverso de esta hoja

Nombre de paciente _____ Firma _____

Fecha de nacimiento _____ La fecha de hoy _____

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Patient Name _____ Gender ☐ M ☐ F Date _____

Date of birth _____ **Marital status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Race: ☐ American Indian ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or other Pacific Islander

☐ Unable to determine or not stated **Ethnicity:** ☐ Hispanic ☐ Other _____

Preferred Language: ☐ English ☐ Spanish ☐ French ☐ Portuguese ☐ Chinese ☐ Janpanese

☐ Italian ☐ Russian ☐ Declined ☐ Unavailable (Unknown) ☐ Other _____

Occupation _____ Retired? ☐ Do you exercise regularly? ☐ Yes ☐ No

Any allergies to medication? ☐ No ☐ Yes If Yes – what side effect or reaction did you get from it:

_____

_____

_____

Substances (Please mark the following)

Caffeine ☐ Never ☐ Past ☐ Current - amount per day _____

Tobacco ☐ Never ☐ Past ☐ Current - amount per day _____

Alcohol ☐ Never ☐ Past ☐ Current - amount per day _____

Patient Medical History
Have you ever had any of the following conditions?

☐ Thyroid
☐ Lung Disease
☐ Diabetes
☐ Arthritis
☐ Kidney Disease
☐ High Blood Pressure
☐ Heart Disease
☐ Stroke
☐ Asthma
☐ Depression

☐ Cancer _____

_____

_____

☐ Surgery (Please list) _____

_____

_____

_____

_____

_____

Family Medical History Does anyone in your family have the following:

Hypertension	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Thyroid	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Heart problems	☐ Yes	☐ No
Bleeding/clotting disorders	☐ Yes	☐ No
Cancer	☐ Yes	☐ No

☐ Other _____

Medications: (Please list your medications you are currently using)

1 _____ dose _____

2 _____ dose _____

3 _____ dose _____

4 _____ dose _____

5 _____ dose _____

6 _____ dose _____

Why are you here? _____

_____

_____

_____

Other current medical problems _____

_____

_____

Richard D. Brand, M.D.
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(805) 983-0425
(805) 983-0414 Fax

Acknowledgement of Receipt of Notice of Privacy Practices
Acuse de Recibo de la Notificación de Prácticas Confidenciales

English

Section A: Acknowledgement of Receipt of Privacy Practice Notice

Please print name: _____

Date of birth: _____

I have received a copy of this office's of Privacy Practices.

Signature: _____

Date: _____

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal representative's name: _____

Relationship to individual: _____

Representative's telephone: ( ) _____

Signature: _____

Date: _____

Section B: Good Faith Effort to Obtain Acknowledgement of Receipt

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify) _____

☐ The updated **Notice of Privacy Practices** has been made available to me.

Signature: _____

Date: _____

Español

SECCIÓN A: *Acuse de Recibo de la Notificación de Prácticas Confidenciales.*

Nombre (letra de imprenta): _____

Fecha de Nacimiento: _____

He recibido una copia de la notificación de las Prácticas Confidenciales.

Firma: _____

Fecha: _____

Si un representante personal firma esta autorización por parte de este individuo complete lo siguiente:

Nombre del representante personal: _____

Relación con el paciente: _____

Teléfono del representante: _____

Firma: _____

Fecha: _____

SECCIÓN B: Esfuerzo de buena fe para obtener el Acuse de Recibo

Tratamos de obtener el acuse de recibo por escrito de nuestra Notificación de las Prácticas Confidenciales, pero el acuse de recibo no se pudo obtener debido a:

- ☐ El paciente se negó a firmar
- ☐ Barreras de comunicación impidieron obtener el acuse de recibo
- ☐ Una situación de emergencia nos impidió el obtener el acuse de recibo
- ☐ Otro (favor de especificar) _____

☐ El puesto al día de la **Notificación de Prácticas Confidenciales** se ha puesto a mi disposición.

Firma: _____

Fecha: _____

Richard Brand, M.D.
A Professional Corporation
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Notice Of Privacy Practices

Release Authorization

As required by law protected healthcare information in your medical record will require a signed authorization to release. Your health care record may include information from multiple physicians, laboratories, hospitals and other entities. Included data such a (sexuality, HIV, mental health, e-mails, etc.), are those in which will remain protected and will require authorization.

Our practice is dedicated to maintaining the privacy of your individually identifiable health information. During the course of providing your medical care, our office will create records regarding you and the treatment and services we give you. Effective April 14, 2003, federal law requires us to give our patients a notice of our privacy practices. This law is complicated and our goal is to help you better understand the Health Information Portability and Accountability Act (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.

Right to a copy of your medical information

To have a copy or your medical information, you must submit a written request to our privacy officer. If you request a copy of your medical information, we may charge a reasonable fee for the cost of labor, postage and supplies associated with your request.

Right to request restrictions

You have the right to request restrictions and or limitations on medical information we use or disclose about your for treatment, payment, or health care operations. If you pay in full for out-of-pocket services obtained in our office, you have the right to request that medical information to those services not be disclosed to any health plans for purposes of payment or health care options. You also have the right to limit medical information to someone who is involved in your care or the payment for your care.

If we agree, we will comply with your request unless restricted information is needed to provide you with emergency treatment. To request restrictions, you must make your request in writing to our privacy officer. Your request must specify exactly what information you would like limited, weather to limit our use, disclosure or both, and to whom you want the limits to apply.

Right to receive notice of breach

We are required to notify you by first class mail on any breaches of unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach. Breach notices have to include the following information:

- A brief description of the breach, including date of breach and date of discovery, if known:
- Description of type or Unsecured Protected Health Information involved in breach
- Steps you should take to protect yourself from potential harm resulting from the breach:
- Description of actions our office is taking to investigate the breach, losses, and protect against further breaches:
- Contact information, including toll free numbers, e-mail address, web site or postal address for questions or to obtain additional information.

Understanding Your Health Record/Information

Each time you visit a hospital, physician, or other health care provider, a record of your visit is made. Typically, this record contains your symptoms, examination and 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 tool in educating health professionals
- a source of data for medical research
- a source of information for public health officials charged with improving the health of the nation
- a tool with which we can access and continually work to improve the care we render and the 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
- make more informed decisions when authorizing disclosure to others

Use and Disclosure of your Medical Information

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. *We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.*

For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

For Payment: We may use and disclose your medical information for payment purposes.

For Health Care Operations: We may use and disclose your medical information, for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

Additional Uses and Disclosure: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes:

Notification: Medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of an emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you. We may also share health information with your relatives and/or personal representatives regarding payment for your care..

Disaster Relief: Medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fund Raising: We may provide medical information to one of our affiliated fund raising foundations to contact you for fund raising purposes. We will limit our use and sharing to information that describes you in general, not personal terms, and the dates of your health care. In any fund raising materials, we will provide you a description of how you may choose not to receive future fund raising communications. You have the right to Opt out completely of any fundraising.

Research in Limited Circumstances: Medical information in research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Function: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security, intelligence activities, protective services, government programs providing public benefits, medical suitability determinations for the Department of State, and for correctional institutions and other law enforcement custodial situations.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical, information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as *a* court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, *we* may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including abuse or neglect. We may also disclose your medical information to the Food and Drug Administration for purposes of reporting adverse events associated with product defects. We may notify a person who may have been exposed to a communicable disease or otherwise be at *risk* of contracting or spreading a disease or condition.

Our Legal Duty

Law Requires Us to:
1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice now in effect.

We Have the Right to:

1. Change our privacy practices and the terms of this notices at any time, provided that the changes are permitted *by law.*

2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:
1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

Question of Complaints:
If you have any questions about this notice or if you think that we may have violated your privacy or rights, please contact us.