ANDREW S. FLOREA M.D., INC.
Specializing in Otolaryngology-Head and Neck Surgery (ENT)
Voice and Swallowing Disorders, and Facial Plastic Surgery

Patient/Physician Arbitration Form

1) 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 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, this arbitration agreement, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use or arbitration.
2) ALL CLAIMS MUST BE ARBITRATED. I understand that all claims for damages arising from medical services rendered by Andrew S. Florea M.D., Inc. and/or associate or substitute physicians, nurses or employees must be arbitrated. This includes any claim of a spouse, heir, child (born or unborn), or other successor in interest to any such claim.
3) ARBITRATION PANEL. Within 30 days of a demand to arbitrate a dispute, which must be made in writing, the parties shall agree on three (3) medical arbitrators. Each party will bear the costs for their own legal counsel, and other expenses incurred for their own benefit, as well as pro rata share of arbitration expenses.
4) APPLICABLE LAW. I agree that the California Code of Civil Procedure relating to arbitration shall apply without any exception.
5) REVOCATION OF THE AGREEMENT. This agreement may be revoked and cancelled by written notice delivered to Andrew S. Florea M.D., Inc. within 30 days of the signing of this agreement. If notice of revocation of this agreement is not received within 30 days of its signing, the right to cancel the agreement is forever waived.
6) RETROACTIVE EFFECT. If the signing party intends this agreement to cover all services rendered before the date of the signing of this agreement (including, but not limited to, prior consultations or treatment), the signing party must initial here:
7) ACKNOWLEDGEMENT. By signing this agreement, the signing party acknowledges he/she discussed to his/her satisfactory any questions he/she may have had regarding the arbitration agreement with Andrew S. Florea M.D., Inc., an associate physician, physician assistant, nurse practitioner, or authorized legal representative of Andrew S. Florea M.D., Inc.
8) If any provision of this arbitration agreement should be held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

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.

Patient Signature (or Guardian if minor): ____

Patient Name:____ Date: ____________________

If signed by someone other than the patient, indicate the relationship:___________________________

Physician's agreement to arbitrate: In consideration of the foregoing execution of the Patient/Physician Arbitration Agreement, Andrew S. Florea M.D., Inc. and staff likewise agree to be bound by the terms set forth in this agreement.

CURRENT MEDICATION RECORD

Patient's Name: ______________________________________
Date of Birth: ______________________________________
Today's Date: ______________________________________

MEDICATIONS: Please list **all** medications you currently take, including appetite suppressants, vitamins, herbal supplements, etc.

Medication Name	Strength	Frequency	Start/End Date	Prescribing Physician	Dispensing Pharmacy

ANDREW S. FLOREA M.D., INC.
NEW PATIENT INFORMATION

Last Name____ **First Name** _________________________ **M.I.** _________________

Address ____ **City** ______________________ **State** _______ **Zip** ______________

Soc. Sec. # _________________________ **CA D.L.#** ______________**Phone #** __________________ **Cell #**__________________

Age _______ **DOB** ___________ **Marital Status:** M S W D Sep. **Gender:** Male Female

Employer ____________________**Occupation** _________________________ **Phone #** _________________________________

Address ____ **City** _______________________ **State** ________ **Zip** ____________

PRIMARY INSURANCE
Name ____________________________________ **Policy #** ______________________________ **Phone #** ____________________

Address ____ **City** _________________________ **State** ________ **Zip** ___________

SECONDARY INSURANCE (if applicable)
Name ____________________________________ **Policy #** ______________________________ **Phone #** ____________________

Address ____ **City** _________________________ **State** ________ **Zip** ___________

INSURED PARTY INFORMATION IF DIFFERENT THAN ABOVE

Name ____ **Phone #** _____________________

DOB ________________ **Soc. Sec. #** __________________________ **Relation** ____

Address ____ **City** _________________________ **State** ________ **Zip** ___________

Ins. Co. Name _________________________________ **Policy #** __________________________ **Phone #** ____________________

Address ____ **City** _________________________ **State** ________ **Zip** ___________

FRIEND OR RELATIVE IN THE AREA

Name _____________________________________**Relationship**________________________ **Phone #** _____________________

Address ____ **City** _________________________ **State** ________ **Zip** ___________

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ANDREW S. FLOREA M.D., INC.
1174 Nevada St. Suite 100
Redlands Ca 92373

Financial Agreement: I hereby authorize you to make payments directly to Dr. Andrew S. Florea for all basic and major medical expenses. I fully understand I am financially responsible for any balance.

Medical Records: Authorization is hereby granted for the release of any information required to process my medical claims. A copy of this authorization is as valid as the original.

Consent for Treatment: I, the undersigned, hereby consent to the administrator of and performance of all diagnostic procedures and treatment, which, in the judgment of my physician, may be considered necessary or advisable. I further agree that if I decide to leave without receiving treatment or without the consent of my attending physician, the physician will not be liable for the consequences of such decision.

___________________________________ ______________________

Patient or Responsible Party Signature **Date**

ANDREW S. FLOREA M.D., INC.

PRACTICE FINANCIAL POLICY

We are committed to providing all our patients with the best possible medical care. If you have medical insurance, we are anxious to help you receive your maximum allowable plan benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

ALL PATIENTS: The patient is responsible for all services rendered regardless of insurance coverage. The full responsibility of payment rests with you, the patient or responsible party. If full payment is not made, we may enlist the services of an outside company to collect in our behalf. We reserve the right to add an additional charge to cover the cost of the collection service.

CASH PATIENTS: All services rendered on a cash basis must be paid in full at the time of service.

PRIVATE INSURANCE: We must have accurate, complete insurance information at the time of service. If you cannot supply us with all the necessary billing information, your account will be handled the same as a cash patient. Any deductible and co-payment amounts are due at the time of service.

MEDICARE: We must have a copy of your Medicare card and any secondary insurance(s). We do accept assignment on Medicare claims, which means that you will be responsible only for your deductible and 20% of allowed charges. There are certain procedures and supplies, which are NON-COVERED services for Medicare patients. If you need such services you will be informed that they are NON-COVERED and if you still wish to receive such services in this office they will be on a cash basis at the time of service.

IF AT ANY TIME YOU SHOULD EXPERIENCE FINANCIAL HARDSHIP, PLEASE MAKE THIS OFFICE AWARE OF THE SITUATION. WE ARE ALWAYS WILLING TO MAKE SPECIAL ARRANGEMENTS FOR THOSE PATIENTS WHO NEED EXTRA HELP. IF YOU NEED TO MAKE ARRANGEMENTS, PLEASE ASK TO SPEAK WITH THE BILLING SUPERVISOR OR MANAGER.

I have carefully read and understand all of the above and accept, approve, and agree to **Andrew S. Florea M.D.** *Practice Financial Policy*.

____ ________________

Patient or Responsible Party Signature **Date**

ANDREW S. FLOREA M.D., INC.

PATIENT MEDICAL HISTORY

PATIENT'S NAME: ____ **DATE:** ___________________________

D.O.B: __________________ **AGE** ___________ **SEX** __________ **HT.** _____________ **WT.** __________

SURGICAL HISTORY: ____

____

PAST MEDICAL HISTORY:

Major Illness: ____

Major Injuries: ____

Positive TB: Yes ____ No ____ When? _______________

REVIEW OF SYSTEMS:

General

Yes No Weakness or Fatigue
Yes No Recent Weight Loss

Eyes

Yes No Blurred Vision
Yes No Double Vision

Ear, Nose, Mouth and Throat

Yes No Trouble Hearing
Yes No Tinnitus or Ringing in Ears
Yes No Ear Pain
Yes No Ear Infection or Drainage
Yes No Dizziness, Vertigo or Unsteadiness
Yes No Stuff Nose
Yes No Sinus Trouble
Yes No Frequent Nose Bleeds
Yes No Frequent Sore Throats
Yes No Pain Near Teeth or Mouth
Yes No Hoarseness or Voice Change
Yes No Difficulty with Swallowing
Yes No Lump in Neck
Yes No Pain in Neck

Cardiovascular

Yes No Heart Trouble
Yes No Palpitations
Yes No High Blood Pressure

Respiratory

Yes No Cough
Yes No Asthma or Wheezing
Yes No Shortness of Breath

Hematologic

Yes No Easy Bruising or Bleeding
Yes No Anemia

Allergic

Yes No Hay fever or Dust/Mold Allergy
Yes No Food Sensitivity or Intolerance
Yes No Chemical Sensitivity

Gastrointestinal

Yes No Heartburn or Acid Reflux
Yes No Nausea or Vomiting
Yes No Diarrhea
Yes No Ulcers
Yes No Frequent Use of Antacids

Genitourinary

Yes No Kidney Problems

Musculoskeletal

Yes No Joint Pains or Stiffness

Integmentary

Yes No Skin Rashes

Neurological

Yes No Headaches
Yes No Numbness in Face, Legs, or Arms
Yes No Seizures
Yes No Weakness in Arms or Legs Yes
No Blackouts or Fainting
Yes No Trouble Speaking
Yes No Confusion or Memory Loss

Psychiatric

Yes No Nervousness or Increased Stress
Yes No Sleep Problems
Yes No Snoring
Yes No Excessive Moodiness or Worry

Endocrine

Yes No Thyroid Problems
Yes No Diabetes

FAMILY HISTORY:

Lung Disease	Yes ____	No ____	Who? ______________________________
Heart Disease	Yes ____	No ____	Who? ______________________________
Diabetes	Yes ____	No ____	Who? ______________________________
Cancer	Yes ____	No ____	Who? ______________________________
Blood Pressure	Yes ____	No ____	Who? ______________________________
Positive TB	Yes ____	No ____	Who? ______________________________

SMOKE: Yes ____ No ____ Quit? Yes ____ No ____ If so, when? ____________________

Cigarettes ___________	How Long ________________	# Packs ___________________	# Cigs ______________________
Cigar ___________	How Long ________________	# Packs ___________________	# Cigs ______________________
Pipe ___________	How Long ________________	# Packs ___________________	# Cigs ______________________

ALCOHOL USE: Yes ____ No ____ Quit? Yes ____ No ____ If so, when? ____________________

Frequently _________________ Social __________________________ Rarely ____________________________

DRUGS: Yes ____ No ____
Type: _____________________ Quit: Yes ____ No ____ If so, when? ________________________________

PLEASE LIST ANY PRIOR (*MOST RECENT*) HOSPITALIZATIONS: ____________________________________

____

____

____

REASON FOR ENCOUNTER: ____

____

____

____

REFERRING PHYSICIAN: _____________________________________

PATIENT CONSENT FORM & NOTICE OF PRIVACY PRACTICES

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining authorization and/or payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operation, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

"I acknowledge that I have received a copy of the Notice of Privacy Practices from Andrew S. Florea M.D."

Print Patient Name: ____

Relationship to Patient: ____

Signature: ______________________________ Date: _______________________

ANDREW S. FLOREA M.D., INC.
1174 Nevada Street Suite 100
Redlands Ca 92373
Phone: 909-335-3000
Fax: 909-335-3001

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

- ❑ Home Telephone # ______________________________
- ❑ Leave message with detailed information.
- ❑ Leave message with call back number only.

- ❑ Work Telephone # _______________________________
- ❑ Leave message with call back number only.

- ❑ Written Communication
- ❑ Mail to my home address.
- ❑ Mail to my work/office address.
- ❑ Fax to this number: ______________________________

- ❑ Other ____

____

I authorize Andrew S. Florea M.D. and/or staff to disclose *PHI* to the following members of my family or person/s responsible for my healthcare (check all that apply):

- ❑ Spouse: Name ____________________________________
- ❑ Daughter/s: Name/s ____
- ❑ Son/s: Name/s ____
- ❑ Extended Care Facility ____
- ❑ Other: ____

____

______________________________________ ______________________

Print Name **Date of Birth**

______________________________________ ______________________

Patient Signature **Date**

ANDREW S. FLOREA M.D., INC.
MEDICAL RECORDS RELEASE AUTHORIZATION

TO: ANDREW S. FLOREA M.D., INC.
1174 Nevada Street Suite 100
REDLANDS, CA 92374
PHONE: 909-335-3000
FAX: 909-335-3001

I HEREBY REQUEST A COPY OF THE FOLLOWING REPORTS:

CONSULT _________________ LABS _______________________

BILLING ____________________ X-RAY ______________________

OTHER ______________________

PLEASE RELEASE THE ABOVE REQUESTED RECORDS TO:

____

____

____

AUTHORIZED SIGNATURE __________________________________

PRINT SIGNATURE __________________________________

DATE OF BIRTH __________________________________

SOCIAL SECURITY # __________________________________

DATE SIGNED __________________________________

ANDREW S. FLOREA M.D., INC.

REQUEST FOR RELEASE OF MEDICAL RECORDS

TO: ______________________________
____
____
____

Phone # ______________________
Fax # ______________________

I HEREBY REQUEST A COPY OF THE FOLLOWING REPORTS:

CONSULT_________________
LABS_______________________
TREADMILL_______________
PROGRESS NOTES____________
X-RAY____________________
EKG_________________________
OTHER____________________

PLEASE RELEASE THE ABOVE RECORDS TO:

ANDREW S. FLOREA M.D., INC.

1174 Nevada Street Suite 100
Redlands, CA 92374
Phone # (909) 335-3000
Fax # (909) 335-3001

Date: _______________

Patient's Name (Please Print):____

Patient's Date of Birth: ____

Patient's Signature: ____

ANDREW S. FLOREA M.D., INC.

Specializing in Otolaryngology-Head and Neck Surgery (ENT)
Voice and Swallowing Disorders, and Facial Plastic Surgery

Dear Sir or Madam,

You have an appointment scheduled with Dr. Andrew S. Florea on ________________________________at _______________ am / pm at our Redland's office. If you are unable to be at your appointment or if this is appointment date/time is not correct, please call the office at (909) 335-3000.

In order to make your appointment run more smoothly, please bring/fill out the following:

- **FORMS:** Please fill out the enclosed forms and bring them with you for your appointment.
- **INSURANCE CARD:** (primary and secondary cards). We will need to make copies of your cards.
- **TEST RESULTS:** (blood work, biopsy, MRI, CT, X-Ray, Ultrasound, PET Scan). We may not be able to get these results the day of your appointment so please get copies of these ahead of time from your primary care physician or the facility where the test was performed.
- **FILMS:** In addition to the reports, please bring in the actual films or a disk (CD-ROM) of the imaging study for the doctor to review as well.
- **CO-PAYs:** (HMO's**,** PPO's and other insurances that require a co-pay). All co-pays must be paid at the time of your visit. There will be an additional processing charge for any uncollected co-pays.
- **REFERRALS:** Please ensure that your referral (if required by your insurance plan) has been obtained or put into the system by your primary care physician's office **before** your appointment. If you do not have a referral on the day of your appointment, it may be rescheduled.
- **MEDICATIONS:** Please bring in a complete list of current medications.

Please be aware that it is your responsibility to know the terms of your insurance plan. We participate with numerous insurance plans, which have very different policies. Our office staff cannot be responsible for knowing your specific plan's policies.

Please keep in mind that you will be responsible to furnish all necessary information for the physician to review at the time of your visit, without this information your appointment may be cancelled and/or rescheduled for a later date. Please arrive promptly to your schedule appointment.

Thank you and we look forward to meeting you and taking care of you.

1174 Nevada St Suite 100
Redlands CA 92373

NOTICE OF PRIVACY PRACTICES

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

Under the health insurance portability & accountability Act of 1996 (HIPAA), all medical records and other individually identifiable health information of which we have knowledge must be kept confidential. All personal health information used by us or disclosed by us is covered by this Act regardless of whether this personal health information is in electronic, oral or on paper form. Several new rights are granted to patients under this Act, allowing control over how your personal health information is used, how you can access it, and in some cases amend it.

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

We may be assessed a penalty for any misuse or unauthorized disclosures of your personal health information as regulated by HIPAA.

This notice of privacy practices is effective on **APRIL 15, 2003.**

We are bound to abide by the terms of this notice and reserve the right to make revision to this policy. Should revision be made, you will be notified in writing, and a copy of the revised policy will be made available at your request.

You will be asked to sign a consent form authorizing us to use and disclose your personal health information only for the following purposes, as defined under the Act:

- Treatment means the provision, coordination, or management of health care and related services by one or more healthcare provider, including the coordination or management of health care by a healthcare provider with a third party; consultation between healthcare providers relating to a patient; or the referral of a patient for health care from one healthcare provider to another. An example of this would be a primary care physician to a pulmonary specialist.
- Payment means obtaining reimbursement for the provision of health care; determinations of eligibility or coverage; billing; claims management; collection activities; justification of charges; and disclosure to consumer reporting agencies; protected health information relating to the collection of reimbursements (only certain information may be disclosed). An example of this would be submitting your bill for health care services to your insurance company.
- Health care operations are any activity related to covered functions in which we participate in the function of our offices, such as conducting quality assessment activities; protocol development; case management and care coordination; auditing functions; business management and general administrative activities, including implementation of this regulation; customer service evaluations; resolution of grievances; fundraising; and marketing for which and authorization is not required. An example of this would be evaluating customer service given to patients.

We may, without prior consent use or disclose your personal health information to carry out treatment, payment of healthcare operations:

- Directly to you at your request;
- In an emergency treatment situation, if we attempt to obtain such consent as soon as reasonably practicable after the delivery of such treatment, if we are required by law to treat you and attempts to obtain consent are unsuccessful, or if we attempt to obtain consent but are unable, due to barriers of communication, but we determine in our professional opinion that treatment is clearly inferred from the circumstances;
- Pursuant to and in compliance with an authorization signed by you; and
- Provided that you are informed in advance of the use and disclosure and have the opportunity to agree to or prohibit or restrict the use or disclosure. This may be an oral agreement between us and may include a directly maintained at our facility containing specific information allowed by this Act.

We may de-identify your personal health information by using codes or removing all individually identifiable health information.

All other uses and disclosure will be made only upon securing a written authorization form signed by you. You have the right to revoke this authorization, at any time, upon written notice and we will abide by that request. However, exception would be any actions already taken, relying on your authorization, prior to revocation of notice.

We may contact you to provide appointment reminders or to inform you about treatment alternatives or other health related benefits or services that may be of interest to you. We may also contact you for fundraising purposes.

Under HIPAA, you have the following rights with respect to your protected health information:

- You have the right to request restrictions on certain uses and disclosures of protected health information, concluding restrictions placed upon disclosure to family members, close personal friends, or any other person you may identify. We are, however, not required to agree with a requested restriction;
- You have the right to receive confidential communications of your protected health information, either directly from us or from us by alternative means or from alternative locations;
- You have the right to inspect and copy your protected health information;
- You have the right to amend protected health information, however, this request may be denied under certain circumstances;
- You have the right to receive an accounting of disclosures of your protected health information made by us in the six years prior to the date of the accounting request; and
- You have the right to obtain a paper copy of this notice from us, even if you have already agreed to receive the notice electronically

If you feel your privacy rights or the provision of this notice of privacy policies has been violated, you have the right to file a formal written complaint. This complaint should be addressed either to the Privacy Officer at our office, or directly to the Department of Health & Human Services and/or the Office of Civil Rights. Both addresses appear below. You will not be retaliated against, in any way, for filing a complaint.

For more information about HIPAA or to file a complaint, contact:

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

Please Contact us for more information:

PRIVACY OFFICER
OFFICE MANAGER
Tel #: (909) 335-3000