Andrew S. Florea M.D.,Inc Medical Group

COMPLIANCE & TEAMWORK

PATIENT NAME_____ DATE OF BIRTH_____

We want you to receive excellent care. The best way to meet this goal is to work together. The doctor-patient relationship is a teamwork scenario. Predictable outcomes depend on both parties understanding and working towards the same goals.

Patient Responsibilities:

- Ask questions, share your feelings, and be part of your care
- Be honest about your history, symptoms, and other important information about your health Tell your doctor about any changes in your health and well-being
- Schedule accordingly based on the recommended care plan and follow your doctor's advice Make healthy decisions about your daily habits and lifestyle
- Prepare for and keep scheduled visits or reschedule visits in advance whenever possible Be respectful to office staff and healthcare providers
- End every visit with a clear understanding of your doctor's expectations, treatment goals, and future plans.

Healthcare Provider Responsibilities:

- Explain diagnosis, treatment recommendations, and outcomes in an easy-to-understand way Listen to your questions and help you make decisions about the direction of your care
- Keep treatments, discussions, and records private
- Provide instructions on how to meet your health care needs when the office is not open Determine when a breakdown of the doctor-patient relationship is justification for terminating care Determine when referral to another provider or specialist is appropriate
- End every visit with clear instructions about expectations, treatment goals, and future plans Share patient information with other providers involved in your health care, as appropriate

I certify that I have read or had read to me the contents of this form. I understand the possible advantages that compliance with professional healthcare recommendations can provide as well as the potential consequences of non-compliance. I attest that I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction.

_____ _____

Patient's or Patient Representative's Signature Date

_____ _____

Provider's or Provider Representative's Signature Date

Andrew S. Florea M.D. Inc. Medical Group

RESOLUTION AGREEMENT, MEDIATION, AND YOUR CARE

We encourage open communication and ask our patients to sign this agreement in which we make contract commitments to each other. It is no surprise that frivolous malpractice claims have a negative impact on healthcare care and can harm the practice and livelihood of a healthcare provider.

Therefore, as additional consideration for professional care provided to me by Provider, I, the patient/guardian, and/or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of healthcare malpractice against Provider.

Furthermore, in the event of a meritorious malpractice case or cause of action, I (the patient) and/or my representative agree to use expert healthcare witness(es) practicing in the same specialty as Provider. I agree that these expert witnesses will be members in good standing of their state board.

In further consideration of this, Provider agrees to the same stipulations.

Patient/guardian and Provider acknowledge that monetary damages may not provide an adequate remedy for breach because such breach may result in irreparable harm to Provider's reputation and business. Patient/guardian and Provider agree in the event of a breach to allow specific performance and/or injunctive relief.

MEDIATION

While we do not anticipate any issues during the course of your treatment if any arise, you and your healthcare provider agree to meet with a neutral mediator for a voluntary conversation before starting formal legal action.

Should a concern arise regarding the healthcare provided by this office, staff, and affiliated healthcare professionals, I agree to mediate first before pursuing legal action. I agree that any usage or inference to a "claim" will be understood and read as a "potential claim" until mediation is complete. This designation allows us to begin in a less formal manner that has been shown to expedite the resolution process. I will also not make any demand for payment before the mediation begins.

I agree that offering to mediate is a mandatory prerequisite to litigation, and that if I file a lawsuit without first demanding mediation, the lawsuit should be dismissed without prejudice until this prerequisite has been met. I agree that this mediation provision is a material part of this contract.

I UNDERSTAND THAT I DO NOT HAVE TO HIRE AN ATTORNEY TO MEDIATE, BUT IF I CHOOSE TO CONSULT WITH AN ATTORNEY, I WILL SHOW THEM THIS PROVISION.

Filing in any court by the Provider to collect fees shall not waive the right to compel mediation of any claim

YOUR CARE:

We want you to receive excellent care. The best way to meet this goal is good communication.

- **YOUR COMMITMENT:**
- Ask questions and be part of your care
- Be honest about your health history and symptoms
- Tell your doctor about any health changes
- Schedule based on the recommended care plan.

- Prepare for and keep scheduled visits or reschedule visits in advance whenever possible
- Be respectful to office staff and healthcare providers
- End every visit with a clear understanding of your doctor's expectations, and treatment goals
- **OUR COMMITMENT:**
- Explain diagnosis, treatment recommendations, and outcomes in an easy-to-understand way
- Listen to your questions
- Keep treatments, discussions, and records private
- Determine when a breakdown of the doctor-patient relationship is justification for terminating care
- Determine when referral to another provider or specialist is appropriate
- Share patient information with other providers involved in your healthcare, as appropriate

I certify that I have read or had read to me the contents of this form. I attest that I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction.

_____ _____

Patient's or Patient Representative's Signature Date

_____ _____

Provider's or Provider Representative's Signature Date

Andrew S. Florea M.D.,Inc. Medical Group

NEW PATIENT INFORMATION

Email:_____

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. MEDICAL GROUP
341 Magnolia Ave Suite 202 Corona CA. 92879 Phone 951-407-9725

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. Medical Group

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. Medical Group

Privacy Officer 951-407-9725

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

□ Parent or guardian of minor patient

□ Guardian or conservator of an incompetent patient

Name and Address of Patient: _____

_____

_____

Por la presente reconozco que he recibido una copia del Aviso de esta práctica médica de prácticas de privacidad. Además, reconozco que una copia del aviso actual será fijada en la zona de recepción, y que una copia de la Notificación de Prácticas de Privacidad modificado estará disponible en cada cita.

Firmado: _____ Fecha: _____

Imprimir Nombre: _____ Teléfono: _____

Si no está firmada por el paciente, por favor indique la relación:

- El padre o tutor del paciente menor de edad
- Tutor o curador de un paciente incompetente

Nombre y dirección del paciente: _____

_____

_____

Assumption of the Risk and Waiver of Liability Relating to Coronavirus/COVID-19

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing and have, in many locations, prohibited the congregation of groups of people.

Andrew S. Florea, M.D., Inc. Medical Group has put in place preventative measures to reduce the spread of COVID-19; however, Andrew S. Florea, M.D., Inc., cannot guarantee that you (or your child(ren) will not become infected with COVID-19. Further, entering the premises of Andrew S. Florea, M.D., Inc. could increase your risk and your child(ren)'s risk of contracting COVID-19.

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that I (and my child(ren)) may be exposed to or infected by COVID-19 by entering the premises of Andrew S. Florea, M.D., Inc., and that such exposure or infection may result in personal injury, illness, permanent disability, and death.

I understand that the risk of becoming exposed to or infected by COVID-19 at Andrew S. Florea, M.D., Inc. Medical Group may result from the actions, omissions, or negligence of myself and others, including, but not limited to physicians, employees, owners, volunteers, visitors, vendors, other patients, and any other people that may be present, and their families.

I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to me (or my child(ren)) including, but not limited to: personal injury, hospitalization, infection, disability, death, illness, damage, loss, claim, liability, or expense of any kind (collectively hereby referred to as "Claims") that I (or my child(ren)) may experience or incur in connection with my (or my child(ren)'s) attendance or presence at Andrew S. Florea, M.D., Inc. Medical Group

On my behalf, (and on behalf of my child(ren)), I hereby release, covenant not to sue, discharge, and hold harmless Andrew S. Florea, M.D., Inc.Medical group and Citrus Place Medical, LLC, its employees, owners, agents, partners, and representatives including Andrew S. Florea, M.D. personally, of and from the "Claims," including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto.

I understand and agree that this release includes any Claims based on the actions, omissions, or negligence of Andrew S. Florea, M.D., Inc., its employees, physicians, agents, owners, landlords, and representatives, whether a COVID-19 infection occurs before, during, or after my attendance on the premises of Andrew S. Florea, M.D., Inc.

Signature _____ Date:_____

Print Name _____

Witness: _____ Date: _____
If also pertains to accompanied child, or children, print

name(s)_____

Patient Name:_____ Date:_____

Have you experienced these symptoms in the last 2-14 days?

	Circle One: (If yes explain)	
• Fever	No	Yes
• Cough	No	Yes
• Shortness of breath or difficulty breathing	No	Yes
• Chills	No	Yes
• Repeated shaking with chills	No	Yes
• Muscle pain	No	Yes
• Headaches	No	Yes
• Sore throat	No	Yes
• New loss of taste or smell	No	Yes
• Congestion/Runny Nose	No	Yes
• Nausea	No	Yes
• Diarrhea	No	Yes

ETDQ-7 Questionnaire

Over the past month, how much has each of the following been a problem for you ?

	No Problem			Moderate Problem			Severe Problem
Pressure in the ears ?	1	2	3	4	5	6	7
Pain in the ears ?	1	2	3	4	5	6	7
A feeling that your ears are clogged or “under water”?	1	2	3	4	5	6	7
Ear symptoms when you have a cold or sinusitis?	1	2	3	4	5	6	7
Crackling or popping sounds in the ears	1	2	3	4	5	6	7
Ringing in the ears ?	1	2	3	4	5	6	7
A feeling that you're hearing is muffled?	1	2	3	4	5	6	7

Name: _____ Date : _____

Sino-Nasal Outcome Test (SNOT-20)

Patient Name:_____ Date Of Birth:_____ Todays Date:_____

The following questionnaire is intended to help define your symptoms and provide valuable information and insights for Dr. Andrew S. Florea, MD. Answer the questions, rating, to the best of your ability the problems you have experienced over the past two weeks.

Consider how severe the problem is when you experience it and how frequently happens. Please rate each item below on "bad" it is

	No Problem	Mild Problem	Mild/slight Problem	Moderate Problem	Severe Problem	Problem as bad as It can be	5 Most important item's
1. Needs to blow nose	0	1	2	3	4	5	___
2. Sneezing	0	1	2	3	4	5	___
3. Runny Nose	0	1	2	3	4	5	___
4. Cough	0	1	2	3	4	5	___
5. Post nasal discharge	0	1	2	3	4	5	___
6. Thick Nasal discharge	0	1	2	3	4	5	___
7. Ear fullness	0	1	2	3	4	5	___
8. Dizziness	0	1	2	3	4	5	___
9. Ear Pain	0	1	2	3	4	5	___
10. Facial Pain/pressure	0	1	2	3	4	5	___
11. Difficulty falling asleep	0	1	2	3	4	5	___
12. Wake up at night	0	1	2	3	4	5	___
13. Lack of good night sleep	0	1	2	3	4	5	___
14. Wake up tired	0	1	2	3	4	5	___
15. Fatigue	0	1	2	3	4	5	___
16. Reduced productivity	0	1	2	3	4	5	___
17. Reduced concentration	0	1	2	3	4	5	___
18. Frustrated/restless/irritable	0	1	2	3	4	5	___
19. Sad	0	1	2	3	4	5	___
20. Embarrassed	0	1	2	3	4	5	___

Please mark the most important items affecting your health (maximum of 5 items)

CURRENT MEDICATION RECORD

Patient's Name:_____ Date of Birth : _____ Todays date : _____
Allergies to Medication :_____
Reaction to medication :_____

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. MEDICAL GROUP

PATIENT MEDICAL HISTORY

PATIENT'S NAME: _____ **DATE:** _____

D.O.B: _____ **AGE** _____ **SEX** _____ **HT.** _____ **WT.** _____

SURGICAL HISTORY: _____

_____

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

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		

PAST MEDICAL HISTORY:

Major Illness: _____

Major Injuries: _____

Positive TB: Yes ____ No ____ When? _____

REVIEW OF SYSTEMS

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 Name:_____