# WELCOME

## Your First Visit

Thank you for choosing Dr. A. David Matian for your health care needs. During your first visit, you will meet our staff, complete a few brief forms and, of course, meet your doctor. As a family medical office, we will try to solve your current medical problem and detect or prevent other health problems. We hope to make the first visit not just an opportunity to deal with any medical concerns you may have but also a time to get acquainted with you.

## The First Examination

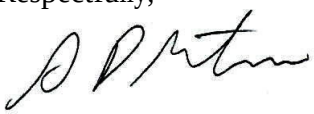
Today, you will be asked to fill out a health questionnaire by a staff member. Dr. Matian will review the health questionnaire. Depending on your medical problem, you may be asked to undress and put on a gown in the privacy of the exam room. This enables the doctor to better evaluate your health. After the examination, your physician will suggest a treatment plan and future visits, if necessary.

We hope that after your visit you will feel confident that you've made a wise decision by choosing our practice. We appreciate any constructive feedback you may have about your experience with us.

## Our Physician

Dr. A David Matian is board certified in family practice and osteopathic manipulation. He is the founder and senior physician in the practice.

Respectfully,



Dr. A. David Matian

# PATIENT REGISTRATION FORM

Patient:_____

Date of Birth: _____ Age: _____ Sex: M F

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____

Cell Phone: _____ Other: _____

Social Security Number: _____ Occupation: _____

Employer: _____ Phone#: _____

Employers Address: _____

Marital Status: __Minor __Single __Married __Widowed __Divorced __Separated

Name of Spouse (or parents if minor): _____

Emergency Contact: _____ Phone: _____

How did you hear about us? _____

## SPOUSE (OR PARENT /GUARDIAN) INFORMATION

Name: _____ DOB: _____ SS: _____

Employer: _____ Phone#: _____

Employers Address: _____

## PAYMENT INFORMATION

Payment is expected at the time of your visit for deductibles, co-payments, and unpaid insurance balances.

Primary Insurance

Name of Insurance Co.: _____

Policy Holder Name: _____

Group#/Policy #_____ Identification #

_____

DOB: _____ SS#: _____ Relationship to Patient: _____

Secondary Insurance

Name of Insurance Co.: _____

Policy Holder Name: _____

Group#/Policy #_____ Identification #

_____

DOB: _____ SS#: _____ Relationship to Patient: _____

# OFFICE POLICY

## APPOINTMENTS

1. It is important that you arrive on time for your appointment. We may need to reschedule if you arrive more than 10 minutes past you appointment time.
2. For legal reasons all patients under the age of 18 must be accompanied by an adult at all appointments, unless a consent form has been signed.
3. All patients are required to go through our cycle of service. This starts on the first visit with a new patient well exam. A follow-up appointment will be made for any specific problems.
4. If you need to reschedule or cancel your appointment we request that you give us a 24-hour advance notice. There is a $50.00 charge for missed appointments.

## FINANCIAL

1. Patient co-payments and deductibles are due at the beginning of each visit.
2. If your insurance is not confirmed before your first visit, a $300 fee will be charged at the time of your appointment. Of course, any amount we receive from your insurance will be refunded to you.
3. We offer a 10% courtesy discount for our patients who do not have an insurance carrier and wish to pay in full at the time services are rendered.
4. Payments are accepted in cash, check, Visa, MasterCard, American Express, and Discover. There is a $50.00 fee on all returned checks.
5. Outstanding and unpaid balances over 30 days will incur a 10% service charge per month unless previous written financial arrangements are satisfied.
6. Chart duplicates require written request from the patient and a $35 fee.

## INSURANCE

1. It is your responsibility to make sure that you are eligible for insurance coverage in our office.
2. You must inform us of any changes in your insurance coverage.
3. As a courtesy we do bill your insurance company. You are responsible for the total payment of treatment until your insurance company has paid their portion of the balance and your account is cleared. Any outstanding insurance claims over 60 days become the patient's responsibility, and must be paid in full at that time to avoid a 5% recurring monthly service fee. We will assist you as much as possible to help you with your insurance benefits.

I understand that I am responsible for my, any treatment is denied by my insurance company, I am not eligible for insurance, I prevent or delay payment by not complying with requests for insurance forms or signatures, I do not complete my treatment and it results in non-payment by the insurance company, lab costs are incurred due to missing appointments, and I received my insurance check and do not send it to your office. I hereby authorize payment directly to the above named physician of the group insurance benefit otherwise payable to me but not to exceed charges that will be incurred in my acceptance of treatment. I understand that I am financially responsible for any changes not covered by this authorization. Upon acceptance of a proposed treatment plan I authorize release of any information relating to this claim. I grant permission to be called at home or work to discuss matters related to this form. I have read the above conditions of this treatment and agree to their contents.

_____

Signature of Beneficiary, Guardian or Personal Representative Date

_____

Please print name Relationship to Beneficiary

# ASSIGNMENT OF RIGHTS AND BENEFITS

Assignment means "to give". This forms means you are giving this office full authorization to act on your behalf in obtaining and collecting money for your health care at this office. You are still responsible for the full payment of your care including the annual deductible, co-payments, and any amounts the insurance company will not pay.

The assignment shall allow Dr. A. David Matian to take all action necessary to obtain the benefits that I have in good faith been promised by my insurance. A photocopy of this assignment shall be considered as effective and valid as the original. I further authorize Dr. A. David Matian to initiate a complaint to the Insurance Commission's office for any reason on my behalf.

I also understand that my insurance policy is a contract between my insurance company and me. If my insurance company does not pay my claim within 30 days after it is received, I agree to remit payment to Dr. A. David Matian within 2 weeks of receiving the bill, and contact my insurance company regarding this settlement. Dr. A. David Matian and his staff will assist me in processing my claim; however, I am ultimately responsible for payment of my account.

I certify that I (and/or my dependent(s)) have insurance coverage and assign directly to Dr. A. David Matian (also known as Matian Medical Corp. and Prime Care Physicians) all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I also authorize my medical information be disclosed for the purposes of medical referrals at my request. This consent will end when my current treatment plan is completed or one year from the date signed below.

[ ] Medicare/Medigap Authorization Medicare No._____

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to: A. David Matian D.O, (also known as Matian Medical Corp. and Prime Care Physicians). For any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any Information needed to determine these benefits or benefits for rotated services.

I do not have to sign this authorization in order to receive treatment from Prime Care Physicians. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to Prime Care Physicians.

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Signature of Beneficiary, Guardian or Personal Representative Date

_____

Please print name Relationship to Beneficiary

# PATIENT HISTORY

Patient:_____

Please list any medications you are taking, including over-the-counter medications:
Name:_____ Dosage: _____ How Often : _____
Name:_____ Dosage: _____ How Often : _____
Have you ever had an allergic reaction to any medication? [ ] Y [ ] N
Name of medications: _____

Medical History: Do you have or have had?

| Illness | Patient | 1⁰ Relative | Illness | Patient | 1⁰ Relative |
|---|---|---|---|---|---|
| Anemia | | | Ulcer | | |
| Asthma | | | Osteoporosis | | |
| HBP | | | Urinary Infections | | |
| Diabetes | | | TB | | |
| Migraines | | | Hay Fever | | |
| Fungal Infections | | | Heart Murmur | | |
| Thyroid Disease | | | Yeast Infections | | |
| Liver Disease | | | Keloids | | |
| Rashes | | | Bladder Problems | | |
| Heart Disease | | | Hepatitis (jaundice) | | |
| Rheumatic Fever | | | Cancer | | |
| DVT | | | Stroke | | |
| Glaucoma | | | Abnormal Scarring | | |
| Breast Problems | | | Kidney Stones | | |
| | | | Pacemaker | | |
| Allergies | | | Cold Sores | | |
| Cancer | | | Stroke | | |
| Heart Attack | | | Blood Clotting Problems | | |

Have you ever been hospitalized? _____
Have you had any surgeries? _____
Have you ever had a blood transfusion? Why?_____
Did your mother take DES when she was pregnant with you? Yes No
Do you smoke? How much?_____
Do you drink alcohol? How much per week?_____
Do you use any recreational drugs? Yes No If yes, which ones?_____
Do you have a history of domestic violence or sexual abuse? Yes No
Do you exercise regularly? How often? _____

# HIPAA NOTICE OF PRIVACY PRACTICES

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 health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information. Please review this notice carefully.

A. Our commitment to your privacy:
Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called protected health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:
- How we may use and disclose your PHI,
- Your privacy rights in your PHI,
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. If you have questions about this Notice, please contact:

Attn: Privacy Officer
Prime Care Physicians
5363 Balboa Blvd. Suite 333
Encino, CA 91316
818-995-7784

## We May Use And Disclose Your PHI In The Following Ways:

1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.
2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly

for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health care operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4 Appointment reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment.

5 Treatment options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

6. Health-related benefits and services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of information to family/friends. Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a baby sitter take their child to the pediatrician's office for treatment of a cold. In this example, the baby sitter may have access to this child's medical information.

8. Disclosures required by law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

## Use And Disclosure Of Your PHI In Certain Special Circumstances:

1. Public health risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths,
- Reporting child abuse or neglect,
- Preventing or controlling disease, injury or disability,
- Notifying a person regarding potential exposure to a communicable disease,
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition,
- Reporting reactions to drugs or problems with products or devices,
- Notifying individuals if a product or device they may be using has been recalled,
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information,
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health oversight activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and similar proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law enforcement. We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement,
- Concerning a death we believe has resulted from criminal conduct,
- Regarding criminal conduct at our offices,
- In response to a warrant, summons, court order, subpoena or similar legal process,
- To identify/locate a suspect, material witness, fugitive or missing person,
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

5. Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies all of the following conditions:
(A) The use or disclosure involves no more than a minimal risk to your privacy based on the following: (i) an adequate plan to protect the identifiers from improper use and disclosure; (ii) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (iii) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted;
(B) The research could not practicably be conducted without the waiver,
(C) The research could not practicably be conducted without access to and use of the PHI.
8. Serious threats to health or safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
9. Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
10. National security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.
11. Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
12. Workers' compensation. Our practice may release your PHI for workers' compensation and similar programs.

## Your Rights Regarding Your PHI:

1. Confidential communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to the following specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests.
2. Requesting restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to above contact. Your request must describe in a clear and concise fashion:

- The information you wish restricted,
- Whether you are requesting to limit our practice's use, disclosure or both,
- To whom you want the limits to apply.

3. Inspection and copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Prime Care Physicians in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your

request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the above contact. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented – for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to Prime Care Physicians. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a paper copy of this notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact to Prime Care Physicians.

7. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Prime Care Physicians. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note: we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact Prime Care Physicians

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Signature of Beneficiary, Guardian or Personal Representative Date

_____

Please print name Relationship to Beneficiary