M . Mark Alwan, M.D.

Patient Information

Patient Name_____Phone_____Cell Phone_____

Address_____ Date of Birth_____ Age_____

City_____ Zip_____ Marital Status_____

Email Address_____

Employer_____ Occupation_____

Address_____ City/Zip_____Work Phone_____

Drivers License_____ Social Security #_____

Insurance Carrier_____ Subscriber ID #_____ Group #_____

Subscriber Name _____ Subscriber Date of Birth _____

Referred By_____ Primary Care Physician_____

Emergency Contact_____ Phone_____ Relationship_____

Pharmacy Name_____ Pharmacy Location_____

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and other plans to M. Mark Alwan M.D. I authorize the disclosure of portions of my medical records to the extent necessary to determine liability for payment and to obtain reimbursement.

The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original. I also understand that I am financially responsible for all charges over sixty days, including any and all late fees added, whether or not paid by my insurance company. If I am not financially able to pay, my guarantor may be held responsible. I hereby authorize the said assignee to release all information necessary to secure payment.

Signature of patient or guardian_____ Date_____

PLEASE NOTE:

- Payment is due at time of service
- Secondary insurance billing will incur a $3.00 charge for each date of service
- A $25.00 fee will be charged for any returned checks
- Any forms, including Disability, EDD, FMLA, etc. are subject to a $15.00 form fee. All forms require 7-10 days for processing

M. Mark Alwan, M.D.
Obstetrics & Gynecology
Phone (909) 981-9991 | Fax (909) 981-1325

Your copay, deductible and/or coinsurance must be paid at the time of service otherwise your appointment will be rescheduled.

Please be advised that effective immediately we will no longer be accepting checks due to an increased volume of bounced checks that we have received. We will however accept checks for any amount over $75.00. A $25.00 fee will be charged for any returned checks.

We do accept Visa, MasterCard or Discover with a fee.

You may receive a bill from a laboratory if any tests or examinations are sent out or conducted outside of this office. **Please be advised that any laboratory fees or bills that you may receive are your responsibility.**

If your insurance does not cover particular laboratory tests, examinations, or requires that you use a specific laboratory for such procedures it is your responsibility to inform this office. Please contact your insurance carrier if you do not know what is covered by your policy.

NOTICE TO CONSUMERS

Medical doctors are licensed and regulated by the Medical Board of California
(800) 633-2322 www.mbc.ca.gov

Physician Assistants are licensed and regulated by the Physician Assistant Committee
(916) 561-8780 www.pac.ca.gov

Please sign below to acknowledge receipt of this notice.

_____

Patient's Signature **Date**

_____

Patient's Name Printed **Date**

M. Mark Alwan, M.D.

Patient Name_____ Age_____ Date_____

Do you take any medications on a regular basis? Yes_____No_____
(please list)

_____

Are there any medications you are allergic to or cannot take? Yes_____No_____
(please list)

_____

Have you ever had surgery? Yes_____No_____
If so, what was done?

_____

Have you ever been hospitalized? Yes_____No_____
If so, why?

_____

Past Medical History

_____Asthma	_____Diabetes	_____Osteoporosis
_____Tuberculosis	_____Thyroid Disease	_____Gallstones
_____Heart Attack	_____Jaundice	_____Drug Use
_____High Cholesterol	_____Hepatitis	_____Glaucoma
_____High Blood Pressure	_____Arthritis	_____Tobacco Use
_____Anemia	_____Mental Illness	_____Alcohol Abuse
_____Depression	_____Abnormal Pap Smear	_____Eating Disorder
_____Cancer If so, what type	_____Sexually Transmitted Infections	
_____Other (please list below)		

_____

_____

Family History

_____Diabetes	_____High Blood Pressure	_____Heart Attack
_____Osteoporosis	_____Cancer If so, what type	_____Stroke
_____Other		

_____

_____

How many times have you been pregnant?_____
How many babies have you had?_____
How many cesarean sections?_____
When was your last pap smear?_____
When was your last mammogram?_____
When was your last period?_____

For Office Use Only:	History number:

Risk Assessment for Hereditary Cancer Syndrome

Patient Name:_____ OB/GYN Name: _____
Date of Birth: _____ Today's Date:_____

Instructions: We are committed to your health and cancer prevention. To best serve you, we need a detailed personal and family cancer history. Please be complete. It is important for your health. If you filled this out within the last 6 months, please SIGN the form, but you do not need to fill it out again. THANK YOU!

		Family History of Cancer	SELF	FAMILY MEMBER		AGE
				MOTHER'S SIDE	FATHER'S SIDE	
Y	N	Breast cancer at age 49 or younger				
Y	N	Ovarian cancer at any age				
Y	N	Bilateral breast cancer				
Y	N	Two relatives on the same side of the family with breast cancer with 1 diagnosis under the age of 50				
Y	N	Three relatives on the same side of the family with breast, pancreatic, prostate and/or ovarian cancer at any age				
Y	N	Triple negative breast cancer under the age of 60 (receptor negative for ER, PR and HER2)				
Y	N	Male breast cancer at any age				
Y	N	Colorectal Cancer 50 years old or younger				
Y	N	Endometrial/Uterine 50 years old or younger				
Y	N	Combination of Colorectal Cancer and any of the following cancers: uterine, small bowel, gastric, brain, pancreatic, renal, ovarian				
		Please list any other cancers in your family				
Y	N	A family member with a known BRCA or Lynch mutation				

Are you of Jewish descent? YES NO

Patient's signature: _____ **Today's Date:** _____

Have you previously had hereditary cancer testing? YES NO

OFFICE USE ONLY

Hereditary Cancer Risk Assessment Testing offered YES NO Date of follow up _____

Patient declined testing. Reason for decline _____

Provider Signature: _____ Date: _____

*All criteria are based on current National Comprehensive Cancer Network Criteria for hereditary cancer diagnosis.

M. Mark Alwan M.D. Obstetrics & Gynecology

INSTRUCTIONS FOR COMMUNICATING PERSONAL HEALTH INFORMATION (PHI)

Dear Patient:

To respect your privacy, please indicate which of the following numbers we should use to communicate with you regarding your treatment in this office, (e.g. appointment confirmations, lab reports, etc.) Only list the number(s) that we are permitted to call/text. Please provide us with the numbers in which we are permitted to leave detailed messages regarding your care or treatment.

Home: _____ Message ? Yes or No

Work: _____ Message ? Yes or No

Cell: _____ Text Message ? Yes or No

Other:_____ Message ? Yes or No

"I_____, authorize my PHI to be communicated
(patient name, please print)

to:_____
_____
_____."

DO NOT communicate my PHI to:

Other Special Requests

_____
_____
_____

Signature: _____ Date:_____
(Patient Signature)

Mark Alwan M.D. 1310 San Bernardino Rd #205, Upland, CA 91786(909)981-9991

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.

☐ I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

_____

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.

☐ Me gustaría recibir una copia del Aviso de Prácticas de Privacidad modificada por e-mail a:

_____

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: _____

_____

_____

NOTICE OF PRIVACY PRACTICES

Mark Alwan, M.D., 1310 San Bernardino Rd. Suite #205, Upland, CA 91786

Phone: (909)981-9991 Fax: (909)981-1325

Effective Date: 04/08/2014

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

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. **Treatment.** We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.

2. **Payment.** We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. **Health Care Operations.** We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality and security of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan, healthcare clearinghouse, or one of their business associates, California law prohibits all recipients of healthcare information from further disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population- based efforts to improve health or reduce health care costs, protocol development, case management or care coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, their activities related to contracts of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts. ***[Participants in organized health care arrangements only should add: We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.]***

4. **Appointment Reminders**. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.]
5. **Sign In Sheet.** We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
6. **Notification and Communication with Family**. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you have instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
7. **Marketing**. Provided we do not receive any payment for making these communications, we may contact you to encourage you to purchase or use products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans we participate in,
   We may receive financial compensation to talk with you face-to-face, to provide you with small promotional gifts, or to cover our cost of reminding you to take and refill your medication or otherwise communicate about a drug or biologic that is currently prescribed for you, but only if you either: (1) have a chronic and seriously debilitating or life-threatening condition and the communication is made to educate or advise you about treatment options and otherwise maintain adherence to a prescribed course of treatment, or (2) you are a current health plan enrollee and the communication is limited to the availability of more cost-effective pharmaceuticals. If we make these communications while you have a chronic and seriously debilitating or life threatening condition, we will provide notice of the following in at least 14-point type: (1) the fact and source of the remuneration; and (2) your right to opt-out of future remunerated communications by calling the communicator's toll-free number. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any financial compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.
8. **Sale of Health Information**. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.
9. **Required by Law**. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
10. **Public Health.** We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
11. **Health Oversight Activities**. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.
12. **Judicial and Administrative Proceedings**. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
17. Proof of Immunization. We will disclose proof of immunization to a school where the law requires the school to have such information prior to admitting a student if you have agree to the disclosure on behalf of yourself or your dependent.
18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
19. Worker's Compensation. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.
21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.
23. Research. We may disclose your health information to researchers conducting research with respect to which. your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.
2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular email account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to another person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal and California law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.
4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. You also have the right to request that we add to your record a statement of up to 250 words concerning anything in the record you believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.
5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.
6. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by email.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend our privacy practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice.
After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. **We will also post the current notice on our website.**

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Region IX
Office for Civil Rights
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
(415) 437-8310; (415) 437-8311 (TDD)
(415) 437-8329 FAX
OCRMail@hhs.gov

The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.