MASSEN MEDICAL

19682 Hesperian Blvd, Suite 101A, Hayward, CA 94541
P: (510) 783-0536 | F: (510) 315-1103

PATIENT INFORMATION REGISTRATION FORM

(PLEASE PRINT)

Patient's Name: _____ DOB: _____
(LAST) (FIRST) (MI)

Address: _____

City_____ State: _____ Zip: _____

Home Phone _____ Cell Phone _____

Work Phone _____ Gender: __M __F Other_____

Soc. Sec. No.: _____ Driver Lic: _____

Marital Status: _____ If Married Spouse's Name: _____

Email Address: _____

Employer: _____ Occupation: _____ Phone: _____

Employer's Address _____City _____ State: _____ Zip: _____

NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY

Name: _____ Phone: _____

Address: _____ Relationship: _____

2ND EMERGENCY CONTACT:

Name: _____ Phone: _____

Address: _____ Relationship: _____

INSURANCE INFORMATION

Primary Insurance Name: _____ Insurance ID #: _____

Secondary Insurance Name: _____ Insurance ID #: _____

Where did you hear about us? Internet __ Google__ Friend__ Yelp__ Other (please specify): _____

Primary Language: _____ **Interpreter needed:** ____Yes ____ No

Preferred Pharmacy / Pharmacy location: _____

I hereby certify that the above information is true. I consent to the medical treatment rendered under the general and special instructions of the physician on duty and I hereby irrevocably assign to **MASSEN MEDICAL INC** all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.

Signature: _____ **Date:** _____
(Patient, Guardian, or authorized representative)

If authorized representative please print name and relationship:_____

ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION RELATED TO MEDICAL SERVICES PROVIDED

I request that payment of authorized Medicare/Insurance Benefits be made on my behalf to **MASSEN MEDICAL INC.** I authorize any holder of medical information about me to release to Health Care Financing Administration, its agents, and Insurance companies any information needed to determine these benefits payables to related services.

I understand my signature requests that payment must be made to **MASSEN MEDICAL INC** and authorizes release of medical information necessary to pay claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance (20% of the approved charge), and non-covered services. Coinsurance and the deductible are based upon the charge determined of the Medicare Carrier.

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OFFICE POLICY

EMERGENCY CARE:
Please contact the office staff regarding your situation and every effort will be made to take care of the problem. In case of an emergency or one in which you are in doubt, please go immediately to the nearest emergency room and ask them to contact the office at (510) 783-0536, or for after-hours at (510) 315-2717.

HOSPITALIZATION:
Dr. Massen has staff privileges for admitting patients at San Leandro Hospital in San Leandro and Eden Hospital in Castro Valley. If necessary, Doctor Massen will admit you to the hospital he feels will provide the best care in treating your condition that is approved by your insurance company.

TELEPHONE CALLS:
If you have any questions regarding your care, please call during office hours or contact the staff via www.patientfusion.com. Messages will be answered in the order received at the earliest convenience. For laboratory procedures and other results please contact the office, and a staff member or the medical provider will return your call as soon as possible after the provider reviews your chart.

APPOINTMENTS:
We see patients *by appointments only*. We try our best to honor your time commitment. Please extend us the same courtesy. All scheduled appointments must be cancelled **24 hours prior to the visit.** If not cancelled 24 hours prior to your scheduled appointment time, a **$50.00 charge** will be applied to your account. **This charge is not payable by your insurance** and is due within 10 days of receiving a bill. **If there is an unpaid balance on the account, no further appointments will be made until the account is paid in full.** To avoid these charges, please make note of the **time and date** you called and the name of the person whom you spoke to. That is the only acceptable confirmation that you will have if you need to dispute the charge. If you are 15 minutes late, you will be asked to reschedule your appointment and still must pay the **$50.00** missed appointment fee. Please note that you are welcome to wait, and we will try to fit you in between patients, but we cannot guarantee that you will be seen**.**

PAYMENT POLICY:
Full payment is due at the time of service, with approved and verified insurance. All co-payments are due at the time of the visit. We accept cash, Visa, Master Card and American Express for co-pay or to pay your balance after your insurance pays. **We do not accept checks.** Appointments may be rescheduled if co-payment is not made.

FEE(S) FOR COMMERCIAL INSURANCE:
Patients with commercial insurance (PPO, HMO) and Covered CA must pay a deposit of $150 (for new patients) and **$120 (**for established patients) at the time of visit. This fee does not include any procedures the provider may order such as: EKG, spirometry, etc.. These will incur an additional cost according to the fee schedule. Once your insurance company pays, the remaining balance will be refunded approximately after 90 days.

REGARDING INSURANCE:
Your insurance policy is a contract between you and your insurance company. It is your responsibility to know your insurance policy. We will assist you in receiving the maximum benefits available to you, but this office is unable to know every insurance policy that is being offered. We file claims as a courtesy to our patients.

Initials: _____

PLEASE NOTE THE FOLLOWING:
You are responsible for knowing what facilities your policy allows you to use for any services such as labs or x-rays. This office is not responsible if you go to a facility that is not covered under your policy. It is the patient's responsibility to correct any error made by this office should we give you a request for an incorrect facility. All insurance coverages must be verified prior to your visit. If we are unable to do so, we may re-schedule your appointment until verification is possible.

It is your responsibility to present the receptionist with your insurance card when you sign-in prior to each visit. Any time your coverage changes; you must inform the **BILLING OFFICE** immediately. Although the office does try to make all changes promptly, if the billing office is not informed within 60 days of any changes, it is possible that you will be responsible for the visit, since there is a very limited time period in which we can file insurance claims.

Any balance due after insurance coverage must be paid promptly upon receipt of a statement from this office. Most insurance companies send an Explanation of Benefits to you when they make a payment for services rendered. We will not become involved in disputes between you and your insurance company regarding your deductible, co-payments, or what charges are covered under your policy other than to supply factual information as necessary. You are responsible for the timely payment of your account.

LABORATORY SERVICES AND X-RAYS:
Please note, you must go to laboratory or radiology departments that are contracted by your insurance only! Otherwise, your insurance will not cover the services.

CLERICAL FEES:
Clerical services are a separate fee from your office visit. They require labor and supplies beyond the normal medical services provided. Clerical fees are not covered by your insurance and are therefore due at the time requested.

Clerical fees are as follows:
- Disability forms, Request for Family Leave, Physical Examination forms.....**$10-$50**
- Disabled Placard, Jury Duty letter, IHSS forms.....**$5**
- DMV DOT forms..... **$100**
- Any letter dictated by Dr. Massen per your request.....**Cost Varies**

Please note: If you require forms to be completed within a 24hr period, there will be an additional $20.00 charge to the clerical fee.

The office staff will try their best to assist you. If there are any concerns regarding medical care and billing, please do not hesitate to contact us. We also appreciate suggestions to improve and establish a positive provider-patient relationship.

COLLECTION ACCOUNTS:
If your account has been transferred to a collection agency for payment, no future appointments can be made until you contact the collection agency to settle your account in full.

Signature of Responsible Party: _____ **Date:** _____

Print Name: _____

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NOTICE TO PATIENTS –OFFICE POLICY

Dear New Patient,

We value you as a patient and appreciate you choosing our clinic for your care. Your health is important to us, and we want to make you aware of our office policy in regards to prescriptions for chronic pain management.

In March 2016, CDC released the CDC Guideline for Prescribing Opioids for Chronic Pain to ensure that patients have access to safer, more effective chronic pain treatment. The Guideline focused on the prescribing of opioid pain medication to patients 18 years and older in primary care settings outside of active cancer treatment, palliative care and end of life care. In addition, the Opioid Crisis Response Act of 2018 and the Medical Board of California has also since implemented practice guidelines for pain treatment among health care providers. These regulations require extensive administrative measures including participation in monitoring programs, increased documentation and database inquiries, and following changing insurance plan and pharmacy requirements. **In order to be in compliance with federal and state regulations, our office does not have the resources, time, and expertise to provide regimens of controlled substance medications for chronic pain.**

We want to ensure patients with chronic pain are able to be cared for by specialists whose training makes them especially qualified to deal with chronic pain. Pain specialists have an in-depth knowledge of the physiology of pain, in addition to a thorough understanding of the skills necessary to perform interventional, pain-reducing procedures. They also can perform the specialized tests necessary for diagnosing pain conditions and are trained in the appropriate prescribing methods for pain medications.

Please note, for chronic pain management, we refer patients to pain management specialists. After the referral, it is your responsibility to ensure that you follow up with the specialist. Although we may provide the names of some specialists, it is important that you also contact and work with your insurance plan to identify specialists within the area, as this list is constantly changing.

If at any time, you do not agree with our office policy, we understand if you decide to choose another primary care provider. In this situation, our office will continue to direct your care over the next 30 days. It is imperative that you select another PCP, and arrange with our office for your records to be sent to the new PCP within the 30 days.

I agree to accept the above conditions. I understand that if I disagree with the above policy, Massen Medical will no longer be able to serve as my primary care provider.

Patient Name (Please print) _____

Patient/Guardian Signature _____

Date _____

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Private Practices.

_____

Please Print Name

_____

Signature

_____

Date

For Office Use Only

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

__ Individual refused to sign

__ Communications barriers prohibited obtaining acknowledgement

__ An emergency situation prevented us from obtaining acknowledgement

__ Other (Please Specify)_____

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HEALTH HISTORY FORM

(All questions contained in this questionnaire are strictly confidential and will become part of your medical record.)

Name *(Last, First, M.I.):*	**DOB:**
Previous Primary Care Provider (Include Name and Last Visit):	

Other Providers/Specialists:

Specialty	Name	Last Visit

Date of last physical exam:	**Date of last laboratory test:**

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations and dates:		
	☐ Tetanus Booster or Tdap :_____	☐ Chickenpox :_____
	☐ Influenza :_____	☐ MMR *Measles, Mumps, Rubella* :_____
	☐ Shingles :_____	☐ Pneumonia :_____
	☐ Hepatitis :_____	☐ Other: :_____

Health Maintenance Screening

	Date of Last (if any):	
Colonoscopy		Abnormal Result? ___Y ___ N
Mammogram		Abnormal Result? ___Y ___ N
Pap Smear		Abnormal Result? ___Y ___ N
TB Test		Abnormal Result? ___Y ___ N

Women's Health

Age at onset of menstruation:_____ Date of last menstruation:_____

Period every _____ days Are you pregnant or breastfeeding? ___Y ___ N

Number of pregnancies _____ Number of live births _____

Any recent breast tenderness, lumps, or other abnormalities? ___Y ___ N

Please list any CURRENT medical diagnoses:	☐ **No known current diagnoses**

Please list any PAST medical diagnoses:	☐ **No known past diagnoses**

Surgeries : ☐ **No history of surgeries**

Year	Reason	Hospital

Other hospitalizations : ☐ **No history of hospitalizations**

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

List your current medications, including any over-the-counter medications ☐ **No current medications**

Name of Medication	Dosage	Frequency Taken

Allergies (Including medications, foods, insects, etc) ☐ **No Allergies**

Allergy	Allergic Reaction

HEALTH HABITS AND SOCIAL HISTORY			
Alcohol	Do you drink alcohol?	☐ Yes	☐ No
	How many drinks per week?		
Tobacco, Illicit Drugs	Do you use tobacco?	☐ Yes	☐ No
	_____Cigarettes/day or _____pks/day _____# of years		
	If past smoker: When quit?_____ For how many yrs did you smoke?_____ How many pks/day did you smoke?_____		
	Do you currently use recreational or street drugs?	If have used in the past, year quit:	
Marital Status	☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Partnered		
	Number of children if any:		

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

Family History of Cancer

Type of Cancer	Which relative, including if father or mother's side	Age of diagnosis if known

OTHER HEALTH CONCERNS

Please check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Musculoskeletal	☐ Mental Health
☐ Head/Neck	☐ Intestinal	☐ Recent changes in weight:
☐ Ears/ Nose/ Throat	☐ Bladder	
☐ Tumors/ Cysts	☐ Bowel	☐ **Sexually transmitted disease history - If yes please specify:**
☐ Chest/Heart	☐ Numbness/ Tingling	
☐ Lungs	☐ Seizures / Paralysis	

Pt Name:_____ **DOB:**_____

TUBERCULOSIS EXPOSURE RISK ASSESSMENT FORM

Patient Name: _____

Age: _____ Date of Birth: _____ Date of Service_____

1. Have you or anyone you see regularly been diagnosed or suspected of being sick with active TB disease? **Yes**___ **No**___

2. Do you have family members or frequent visitors who were born in high TB prevalent countries (most countries from Asia, Africa, Latin America, parts of Eastern Europe)? **Yes**___ **No**___

3. Where you born in, or travel to high TB prevalent countries (most countries from Asia, Africa, Latin America, parts of Eastern Europe)? **Yes**___ **No**___

4. Do you live in and out of home placements (such as board & care or residential facilities)? **Yes**___ **No**___

5. Do you have HIV infection or other immunosuppressive conditions? **Yes**___ **No**___

6. Do you live with someone with HIV seropositivity? **Yes**___ **No**___

7. Do you live or frequently visit, with persons who have been incarcerated in the last 5 years? **Yes**___ **No**___

8. Do you live among or been frequently around individuals who are homeless, migrant workers, users of street drugs, or residents in nursing homes? **Yes**___ **No**___

9. Do you consume alcoholic beverages? **Yes**___ **No**___
   If so, how much? _____

Instructions to healthcare worker:
Report to medical provider/ administer the Mantoux TB skin test to all adults who have any of the above risk factors (indicated by a yes response) UNLESS:
1. The patient has previously DOCUMENTED* positive Mantoux test, or
2. The Patient has had a PPD with the last year.

Health Care Personnel Completing Form_____ Date_____
Name & Title

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Arkady Massen, MD
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AUTHORIZATION TO RECEIVE HEALTHCARE INFORMATION

(This form allows Massen Medical to **request and receive** your medical records from another medical provider or organization. Please fill out a separate form for each provider.)

Patient's Last Name: _____ Patient's First Name: _____

Previous Name If Any: _____ Date of Birth: _____

Address: _____

I HEREBY AUTHORIZE RECORDS TO BE RECEIVED FROM :

Name of Other Provider/Organization: _____

Address, City, State: _____

Phone: _____ Fax: _____

Information to be disclosed:

☐ Records from ____/_____ (mm/yyyy) to ____/_____ (mm/yyyy)
☐ Two years of medical records
☐ All records
☐ Labs ☐ X-Rays ☐ Imaging ☐ Immunizations ☐ Medication lists
☐ Other Information (Please specify):

(If emailing records, please email to info@massenmedical.com)

_____

I understand that the medical information disclosed may contain any and all information concerning treatment of medical history, mental illness, alcohol/drug abuse and HIV/AIDS records.

PURPOSE: The health information disclosed will be used for continuing care or treatment purposes.
REVOCATION: You or your representative can revoke this authorization upon written request. If you revoke, it will not affect information disclosed before the receipt of written request.
DURATION: This authorization shall remain in effect for one year from the date of signature below or unless specified _____ (Date)
A copy of this authorization is as valid as the original. I have the right to have copy of this authorization.

Signature: _____ **Date:** _____
(Patient, Guardian, or authorized representative)

If authorized representative please print name and relationship:_____

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

(This form allows Massen Medical to **release** your medical records to another person or organization. Please fill out a separate form for each recipient.)

Patient's Last Name: _____ Patient's First Name: _____

Previous Name If Any: _____ Date of Birth: _____

Address: _____

I HEREBY AUTHORIZE RECORDS TO BE RELEASED TO:

Name of Recepient: _____

Address, City, State: _____

Phone: _____ Fax: _____ Email: _____

Information to be disclosed:
☐ Records from ____/_____ (mm/yyyy) to ____/_____ (mm/yyyy)
☐ Two years of medical records
☐ All records
☐ Labs ☐ X-Ray ☐ Imaging ☐ Immunizations ☐ Medication lists
☐ Other Information (Please specify):
_____

Purpose of disclosure: ☐ Continuity of care ☐ Insurance ☐ Personal ☐ Other _____

Please check if you give permission to release the following information:
☐ HIV/AIDS ☐ Mental health ☐ Substance abuse ☐ Sexually transmitted disease ☐ Genetic testing

Delivery preference: ☐ Paper ☐ Electronic: (Email, USB, CD, Other) Please specify:_____

I understand that I have the following rights with respect to this authorization:
1. The recipient of the protected health information is prohibited from redisclosing the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law.
2. I may not be required to sign this authorization as a condition to obtaining treatment or payment or my eligibility of benefits.
3. MASSEN MEDICAL INC. will provide me with a copy of this authorization.
4. I may revoke this authorization at any time by mailing or personally delivering a signed, written notice of revocation to MASSEN MEDICAL INC.
5. Once this information is released, it may not be protected under federal privacy law (HIPAA) State or other federal law may require the recipient to obtain your authorization before further disclosure.
DURATION: This authorization shall remain in effect for one year from the date of signature below.

Signature: _____**Date:** _____
(Patient, Guardian, or authorized representative)

If authorized representative please print name and relationship:_____

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CONSENT FOR EMAIL OR TEXT USAGE FOR APPOINTMENT REMINDERS AND OTHER HEALTHCARE COMMUNICATIONS

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/ general information at that email address or text number from the practice.

Cell Phone number:

_____

Email address:

_____

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Patient Name (please print): _____ DOB:_____

Patient/Guardian Signature: _____

Date:_____