Vista Del Mar Medical Group, Inc.

Health Questionnaire

OXNARD OFFICE
1200 West Gonzales Road
Suites 100 & 300
Oxnard, CA 93036
(805)983-0691

VENTURA OFFICE
4567 Telephone Road
Suite 102
Ventura, CA 93003
(805)644-6673

CAMARILLO OFFICE
2412 Ponderosa Drive North
Suite B-100
Camarillo, CA 93010
(805)482-5699

SANTA PAULA OFFICE
242 East Harvard Blvd.
Santa Paula, CA 93060
(805)983-0691

To best serve your medical needs, we ask that you fill out the following questionnaire as completely as possible. The health care provider- health care consumer relationship is a privileged relationship built on trust and honesty. By signing this form you understand that any false information may adversely affect your health.

Name _____ **D.O.B.** _____/_____/_____ **Gender:** ☐**Male** ☐**Female**

Race:
☐ American Indian/Alaska Native
☐ Asian
☐ Black/African American
☐ Native Hawaiian/ Pacific Islander
☐ White
☐ Other Race
☐ Unknown
☐ Decline to State

Ethnicity:
☐Hispanic or Latino
☐Unknown
☐Not Hispanic or Latino
☐Decline to State

Marital Status: _____ Occupation: _____

If you have a personal history of the following, circle those that apply and explain if necessary.

Hypertension
Tuberculosis
Pneumonia
Heart Attack
Diabetes
Asthma
Heart Disease
Stroke

Explanation: _____
_____
_____
_____

If you have had any surgeries in the past, List surgery type and approximate date(s):
Surgery _____ Date: _____
Surgery _____ Date: _____
Surgery _____ Date: _____
Surgery _____ Date: _____

Do you take any medications? (List type of medication, dosage and the manner in which you take it)
_____
_____
_____

Do you have any allergies? _____
Have you had any injuries? _____
Factures: _____ Back injuries_____ Whiplash:_____
Do you smoke? _____ Packs per day: _____ How many years: _____
Do you drink? _____ #/Type per day: _____ How many years: _____
Drug uses other than listed above?_____
Any recent weight change?(Please explain): _____
Any recent fever? (Please explain):_____

Childhood Illnesses? (Circle all that apply):
Rheumatic Fever Scarlet Fever Diphtheria Polio Other:_____

Family History

Mother: Age_____ Any diabetes, heart disease, high blood pressure? (Circle all that apply)
Father: Age_____ Any diabetes, heart disease, high blood pressure? (Circle all that apply)
Brother(s)/ Sister(s): Ages/ Medical Problems:_____
_____
_____

Please circle Y(Yes) or N (No) to answer the following questions:
Have you **recently** had any of the following:

HEAD
Headaches Y N
Dizzy Spells Y N
Head Injuries Y N

NOSE
Bleeding Y N

LUNGS
Asthma Y N
Bronchitis Y N
Emphysema Y N
Cough Y N
Cough up Blood Y N

STOMACH
Loss of appetite Y N
Difficulty w/ swallowing Y N
Stomach pain Y N
Ulcers Y N
Vomiting Y N
Vomiting Blood Y N
Gallbladder Y N
Hepatitis Y N
Jaundice Y N
Constipation Y N
Diarrhea Y N
Hemorrhoids Y N
Diarrhea Y N
Change in bowel habits Y N
Hernias Y N

DERMATOLOGIC
Rash Y N
Suspicious Moles Y N

EYES
Double vision Y N
Blurred vision Y N
Glasses Y N
Contacts Y N
Cataracts Y N
Glaucoma Y N

MOUTH
Sores Y N
Dentures Y N

HEART
Chest Pain Y N
Palpitations Y N
Irregular Heartbeat Y N
Swollen Ankles Y N
Wake up short of breath Y N
Short of breath with activity Y N

ENDOCRINE
Thyroid problem Y N
Diabetes Y N
High Cholesterol Y N

GENITOURINARY
Night time urination Y N
Pain with urination Y N
Blood in urine Y N
Bladder infections Y N
Kidney stones Y N
Trouble starting urine Y N
Loss of bladder control Y N
Prostate problems Y N

HEMATOLOGIC
Transfusions Y N
Anemia Y N
Clotting Problems Y N

EARS
Hard of hearing Y N
Ringing in ears Y N
Ear infections Y N
Discharge Y N

NECK
Chronic Pain Y N

BREAST
Lumps Y N
Pain Y N
Discharge Y N

GYNECOLOGIC
Abnormal bleeding Y N
Vaginal discharge Y N
# of pregnancies ____
# of miscarriages ____

BONES & JOINTS
Pain/swelling joints Y N
Muscle cramps Y N
Arthritis Y N
Gout Y N
Osteoporosis Y N
Back Pain Y N
Leg cramps with exercise Y N
Do fingers change Colors in the cold Y N

NUEROLOGIC
Seizures Y N
Blackouts Y N
Numbness Y N
Paralysis Y N

Patient Signature_____ **Date**_____

Thank you for helping us best serve your healthcare needs.

VISTA DEL MAR MEDICAL GROUP, INC.

"Your Personal Private Physician"

The following policies support the relationship between the patient and her/his physician. Please read the policies and sign after you have read them.

Patients who regularly fail to keep appointments cause other patients to be seen at a later date. Because of this, and the risks that can occur when your medical care is not supervised as you VDM physician feels is correct, we may be dismiss you from the practice for failure to keep appointments.

Our practice meets the needs of patients with chronic to severe medical needs. If during a period of two years you have not been scheduled visits at one of our four offices, then we may elect to dismiss you from our practice for chronic failure to comply with the doctor's care.

Dozens of health insurance companies sell insurance to California. Each company has dozens of plans. Even Medicare has multiple plans. We do our best to understand these plans but we cannot guarantee we understand all the plans maintained by our patients. **Your best financial guarantee is to know your plan, know the physicians on the panels, know the diagnostic centers you can use, and know your deductibles, copays, or coinsurance.** We practice medicine, not insurance.

Please remember to ask for a written prescription for all your medications at the time of your regular office visit. We cannot refill prescriptions by phone, fax or email.

Copays must be made before you see the physicians: any outstanding bills must be settled.

I have read the policies: _____

Printed Name: _____

Date: _____

We appreciate your support of these policies.

Richard Westerdoll
Executive Director

VISTA DEL MAR MEDICAL GROUP, INC.

"Your Personal Private Physician"

INSURANCE RELEASE

To Our Patients,

We are participating providers in many health plans, independent practice associations (IPAs), preferred provider organizations (PPOs), Medicare, and also provide specialty services for many of the area's health maintenance organizations (HMOs) and CHAMPUS.

We will bill your Medicare, and your private insurance if you have secondary coverage, for you at no charge to you.

If you belong to a preferred provider organization, or an HMO with which we participate, we will bill this insurance for you in accordance with our contract.

Your responsibility is for all copayments required by your insurance contract and these copayments will be collected in advance of your service.

Additionally, it is your responsibility to keep our office informed of changes in your health insurance. If you have not informed us of change, we will be forced to hold you personally responsible for services rendered. Additionally, many of the health plans have prior authorization requirements, particularly if our physician is not named as your primary care provider. **If your insurance requires prior authorization for your visit, you will not be seen without prior authorization**.

I have read and understand all of the above: _____ _____
Patient Name Date

I authorize payment of Medicare benefits to:
Vista Del Mar Medical Group, Inc. _____ _____
Patient Name Date

I authorize payment of medical benefits to:
Vista Del Mar Medical Group, Inc. _____ _____
Patient Name Date

In accordance with HIPPA rules I authorize release of any medical information necessary to process this claim _____ _____
Patient Name Date

PRESCRIPTION DRUG RELEASE

I understand that a part of the treatment to be received by me from Vista Del Mar Medical Group, Inc. may include the prescription by physicians employed by it of drugs which contain the risk of prompting adverse reactions among the portion of the persons using them. In making the determination to prescribe such drugs, these physicians take into account the possible or probable injurious effects from the use of these drug, as well as probability of a successful outcome of the treatment. These physicians will attempt to provide an explanation of the common side effects of any such drug prescribed, but this explanation will not include a lengthy discourse on all possible complications. However, I do understand that if I Request, I will be furnished by the physician a full copy of the directions and warnings prepared by the pharmaceutical manufacturer relating to the known consequences of the drug's use.

I HAVE READ, UNDERSTAND, AND APPROVE OF THE ABOVE AND SPECIFICALLY RELEASE VISTA DEL MAR MEDICAL GROUP, INC. , ITS AGENTS AND EMPLOYEES FROM ANY LIABILITY TO ME AND MY FAMILY WHICH I MAY CLAIM RESULTING FROM A LACK OF CONSENT OR LACK OF INFORMED CONSENT ON MY PART WITH RESPECT TO ANY SUCH PRESCRIPTION DRUG.

SIGNATURE:_____ DATE:_____

PRESCRIPTION REFILL POLICY

The Physicians of Vista Del Mar Medical Group, Inc. do not refill medications over the telephone. This is a policy that was put into effect in June of 1993 due to new regulations from the government regarding prescription refills as well as an internal decision by your physicians

Please be sure, each time you have an appointment with your physician in the office, that you review all of your medications with him and ask for any refills which you may need prior to your next office appointment.

If you run out of medication before your next visit you will be required to come in to see your physician or one of the on call physicians in the group to obtain your refill.

I HAVE READ AND UNDERSTAND THE ABOVE STATED POLICY REGARDING PRESCRIPTION REFILLS.

SIGNATURE:_____ DATE:_____

Notice of Privacy Practices

Vista Del Mar Medical Group, Inc.

1200 W. Gonzales Rd., Oxnard, CA 93036

Richard Westerdoll, Privacy Officer, 805/983-0691

Effective Date: April 14, 2003

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.

TABLE OF CONTENTS

A. How this Medical Practice May Use or Disclose your Health Information.....p. 2

B. When This Medical Practice May Not Use or Disclose Your Health Information.....p. 5

C. Your Health Information Rights.....p. 5

1. Right to Request Special Privacy Protections
2. Right to Request Confidential Communications
3. Right to Inspect and Copy
4. Right to Amend or Supplement
5. Right to an Accounting of Disclosures
6. Right to a Paper Copy of this Notice

D. Changes to this Notice of Privacy Practices.....p. 7

E. Complaints.....p. 7

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 of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan, or healthcare clearinghouse, under California law all recipients of health care information are prohibited from re-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 efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

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 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 judgement in communication with your family and others.

7. Marketing. We may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you, or to provide you with small gifts. We may also encourage you to purchase a product or service when we see you. We will not use or disclose your medical information without your written authorization.

8. 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.

9. 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 judgement, 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.

10. 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.

11. 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.

12. 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 or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

13. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

14. Organ or tissue donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

15. 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.

16. 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.

17. 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.

18. 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.

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 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. We reserve the right to accept or reject your 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 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 and

whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by California law. We may deny your request under limited circumstances. If we deny your request to access your child's records because we believe allowing access would be reasonably likely to cause substantial harm to your child, 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. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

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 16 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for proposes 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 the right to a paper copy of this Notice of Privacy Practices.

If you would like 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 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 Notify 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 you may request a copy at any future appointment.

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:

Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Bldg.
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

You will not be penalized for filing a complaint.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Vista Del Mar Medical Group, Inc.
1200 West Gonzales Road, Oxnard, California 93036
Richard Westerdoll, Privacy Officer
(805) 983.09691

I hereby acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice of has been posted in the reception areas, and that I will be offered a copy of any amended Notice of Privacy Practices.

Signed: _____ Date:_____

Printed Name: _____ Telephone:_____

If not signed by the patient, please indicate:

Relationship:

_____ parent or guardian of minor patient

_____ guardian or conservator of an incompetent patient

_____ beneficiary or personal representative of deceased patient

Name of Patient:_____