

FINANCIAL INFORMATION

PATIENT NAME: _____ **DATE:** _____

INSURANCE INFORMATION:

NAME OF INSURANCE PROVIDER: _____

NAME OF INSURED: _____

MEDICAL GROUP (IF APPLICABLE): _____

POLICY NUMBER(S): _____

SECONDARY INSURANCE (If applicable) _____

NAME OF INSURED: _____

MEDICAL GROUP (IF APPLICABLE): _____

POLICY NUMBER(S): _____

CREDIT CARD INFORMATION:

CARD TYPE: V/MC/AMEX NUMBER: _____

EXPIRATION DATE: _____

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I hereby authorize Drs. Kerner, Pleet or their designees to bill my insurance carrier, medical group or other healthcare organization for services provided on my behalf. By placing my initials after the following paragraphs and placing my signature below, I understand that I (or guardian or designee) am financially responsible for my medical care regardless of insurance eligibility or enrollment status at the time services are rendered. This includes any diagnostic services, office-based procedures, and medical management provided to me in the course of my care.

Initials of Patient or Responsible Party

As a courtesy to you we will bill your insurance. If your insurance fails to pay within 30 days of the primary payment, the balance will be forwarded to you or charged to the above credit card.

Initials of Patient or Responsible Party

Appeals: I hereby consent for Marc M. Kerner MD, Inc. to act on my behalf in pursuing any insurance appeals necessary to obtain payment for services rendered. I acknowledge that insurance appeal advocacy does not constitute legal representation, and that I may retain outside legal counsel to participate concurrently, if I so choose.

I understand that if it is determined after any and all medical services are rendered that my eligibility had been terminated by my health plan or medical group, or that the services provided did not have proper authorization, I am financially responsible for all outstanding balances that are accrued. I also acknowledge that I am financially responsible for any and all services rendered that are determined by my health plan or insurance carrier to be either a) a non-covered service; b) medical services that are excluded from my policy for whatever reason; or c) medical services considered by my health plan or insurance carrier to be "cosmetic" in nature and not covered by my policy. I also acknowledge that any outstanding balances not paid within 120 days of services rendered may be turned over to a collection agency which could have an adverse effect on my credit rating.

X _____
Signature of Patient / Guardian /Responsible Party

Date

**SUMMARY NOTICE OF PRIVACY PRACTICES
MARC M. KERNER, MD, INC.**

This is a summary of our Notice of Privacy Practices, which describes how we may use and disclose your medical and personal information and how you can have access to this information. We have attached a full version of the notice.

OUR PLEDGE TO PROTECT YOUR PRIVACY

Our staff is committed to protecting the privacy of your medical and personal information. So that we may best meet your medical needs, we share your medical records with the health care providers involved in your care. We share your information only to the extent necessary to collect payment for the services we provide, to conduct our business operations, and to comply with the laws that govern health care. We will not use or disclose your information for any other purpose without your permission.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

- to inspect and obtain a copy of your medical records with certain limitations;
- to request an amendment or addendum to your medical record;
- to an accounting of Marc M. Kerner, MD, Inc disclosures of your medical information;
- to request restrictions on certain uses and disclosures of your medical information;
- to request when and where to contact you;
- to request a copy of the full version of this our Notice of Privacy Practices.

WE MAY USE AND DISCLOSE YOUR PERSONAL AND HEALTH INFORMATION WITHOUT YOUR AUTHORIZATION FOR THE FOLLOWING PURPOSES:

- to provide you with medical treatment;
- to bill and receive payment for the treatment received;
- as required and permitted by law.
- for functions necessary to run Marc M. Kerner, MD, Inc. and assure that our patients receive quality care;
- for public health activities (e.g. reporting abuse);
- for research purposes in limited circumstances;
- to a coroner, medical examiner, funeral director or organ procurement organization for certain purposes;
- to a court or administrative order, subpoena, discovery request or other lawful process;
- to a health oversight agency, such as the California Department of Health Services;

We reserve the right to change our privacy practices and update this Notice accordingly. Please see our full Notice of Privacy Practices for a more detailed description of our privacy practices.

For further information about the full Notice of Privacy Practices, please contact our Privacy Officer, Mimi Williams, RN, BSN at (818) 349-0600.

I have read and understood my rights and Marc M. Kerner, MD, Inc. Privacy Standards.

Signature of Patient or Legal Representative
If Legal Representative, indicate relationship to patient:

Date

MEDICAL HISTORY

ALLERGIES TO MEDICATIONS OR FOODS: _____

PLEASE DESCRIBE THE PROBLEM(S) FOR WHICH YOU ARE CONSULTING WITH THE DOCTOR?

CURRENT MEDICATIONS: (PLEASE LIST WITH DOSAGES. INCLUDE VITAMINS, HERBS, HOMEOPATHIC REMEDIES, AND OVER-THE-COUNTER MEDICATIONS ESPECIALLY ASPIRIN OR IBUPROFEN MEDICATIONS):

PLEASE LIST ANY PRIOR SURGERIES WITH DATES:

HAVE YOU EVER HAD DIFFICULTY WITH ANESTHESIA? YES /NO. IF YES, PLEASE DESCRIBE:

PLEASE TELL US ABOUT YOUR CHRONIC MEDICAL PROBLEMS? (PLEASE LIST AND DESCRIBE AS BEST AS YOU CAN)

DO YOU SMOKE Y/N IF YES HOW MUCH? _____

IF NO, WHEN DID YOU QUIT? _____

ALCOHOL USE: Y/N: _____

PLEASE TELL US ABOUT YOUR FAMILY MEDICAL HISTORY IN THE FOLLOWING SPACE PROVIDED:

PLEASE CIRCLE ANY OF THE FOLLOWING CONDITIONS IF THEY APPLY TO YOU, AND USE THE SPACE AT THE RIGHT TO DESCRIBE YOUR ANSWERS IN MORE DETAIL:

GENERAL MEDICAL CONDITIONS

- ANY RECENT WEIGHT GAIN
- ANY RECENT WEIGHT LOSS
- ANY RECENT USE OF INTRAVENOUS DRUGS
- HISTORY OF SKIN CANCERS
- REACTIONS TO MEDICATIONS
- DIFFICULTY HEALING WOUNDS

VISION AND HEARING

- GLAUCOMA
- DRY EYE PROBLEMS
- VISION PROBLEMS
- CATARACTS
- HEARING LOSS
- RINGING IN THE EARS
- DIZZINESS
- HISTORY OF EAR SURGERY

MEDICAL HISTORY(continued)

BLOOD DISEASES

EASY BRUISING/BLOOD CLOTTING PROBLEMS
FAMILY HISTORY OF BLEEDING PROBLEMS
LYMPHOMA/LEUKEMIA

CARDIAC

SHORTNESS OF BREATH
HIGH BLOOD PRESSURE
HEART ATTACK
IRREGULAR HEARTBEAT
PACEMAKER

PULMONARY

ASTHMA
CHRONIC LUNG DISEASES, I.E. EMPHYSEMA:
SNORING
SLEEP APNEA
DAYTIME SLEEPINESS
DIFFICULTY BREATHING THROUGH NASAL PASSAGES
CHRONIC RUNNY NOSE
POSTNASAL DRIP
LOSS OF SMELL OR TASTE
RECURRENT SINUS INFECTIONS
ANY CHANGES IN YOUR VOICE
HOARSENESS
COUGHING UP BLOOD

GASTROINTESTINAL SYSTEM

DIFFICULTY SWALLOWING
REFLUX OF STOMACH ACID
PEPTIC ULCERS
ABDOMINAL HERNIAS
BLOOD IN STOOL
VOMITING
CONSTIPATION
HEPATITIS
HISTORY OF LIVER PROBLEMS
JAUNDICE
GALL BLADDER DISEASE

KIDNEY PROBLEMS

URINARY BLOCKAGE
KIDNEY STONES
URINARY TRACT INFECTIONS
PROSTATE

ENDOCRINE

DIABETES
THYROID DISORDERS
EXCESSIVE THIRST
EXCESSIVE COLD
FATIGUE

NEUROLOGIC DISEASES

STROKE
WEAKNESS
MUSCLE DISORDER
DEPRESSION
PSYCHIATRIC DISORDERS

GYN HISTORY:

ONSET OF MENSTRUAL CYCLE? _____
APPROXIMATE DATE OF MENOPAUSE: _____
IRREGULAR CYCLES? Y/N
COULD YOU BE PREGNANT? Y/N