Annie A. Barseghian MD Inc.
FAMILY MEDICINE

800 Fairmount Ave, Suite 210
Pasadena CA 91105
626-381-9599

Name:					**Date:**
PATIENT INFORMATION (please print)					
Gender:	**DOB:**	**SSN:**	**Driver's License Number:**	**Expiration Date:**	**State:**
Home Phone:		**Work Phone:**	**Mobile Phone:**	**Email:**	
Address:			**City:**	**State:**	**Zip Code:**
Ethnicity:			**Preferred Language: (if not English)**	Do you have an Advanced Directive? Yes___ No__ If no, are you interested in information?_____	
INSURANCE INFORMATION (please give your insurance card(s) to the receptionist					
Occupation:		**Employer:**	**Employer Address:**		**Employer Phone:**
Primary Insurance:			**Secondary Insurance: (if applicable)**		
Policy Holder's Name: (as it appears on insurance card)			**SSN:**		**DOB:**
Group Number:			**Policy Number:**		**Co-Pay:**
IN CASE OF EMERGENCY					
Emergency Contact: (local friend or relative)			**Relationship to Patient:**	**First Phone Number:**	**Second Phone Number:**
Referred by:					
SURGERIES					
1.	**Date:**		**2.**		**Date:**
3.	**Date:**		**4.**		**Date:**
DRUG ALLERGIES (please indicate exact type of reaction)					
1.			**2.**		
3.			**4.**		

Annie Barseghian MD

800 Fairmount Ave, Suite 210
Pasadena CA 91105

Name:	Date:

PAST/PRESENT MEDICAL PROBLEMS

☐	Acid Reflux	☐	Emphysema/Chronic Bronchitis	☐	Kidney Disease, Type:
☐	Allergies/Hay Fever	☐	Epilepsy/Seizures	☐	Kidney Stones
☐	Anemia	☐	Gallstones	☐	Liver Disease, Type:
☐	Anxiety/Panic Attacks	☐	Glaucoma	☐	Migraines
☐	Asthma	☐	Gout	☐	Obesity
☐	Autoimmune Disease	☐	Headache	☐	Osteoarthritis
☐	Back Pain	☐	Heart Attack	☐	Osteoporosis
☐	Bleeding from Bowels	☐	Heart Murmur	☐	Prostate Problems
☐	Bleeding Problems, Type:	☐	High Blood Pressure	☐	Skin Problems, Type:
☐	Blood Clot	☐	High Cholesterol	☐	Stroke
☐	Cancer, Type:	☐	Irregular Heart Beat	☐	Thyroid Problems
☐	Congestive Heart Failure	☐	Irritable Bowel Syndrome	☐	Urinary Incontinence
☐	Depression	☐	Insomnia	☐	Other:
☐	Diabetes/High Blood Sugar	☐	Joint Pain	☐	Other:

PLEASE LIST ALL PHYSICIANS WHOSE CARE YOU ARE CURRENTLY UNDER

1.	Location:	2.	Location:
3.	Location:	4.	Location:

FAMILY HISTORY

☐	Alcohol/Drug Addiction	☐	Glaucoma	☐	Osteoporosis
☐	Anxiety or Depression	☐	Heart Attack	☐	Stroke
☐	Asthma	☐	High Blood Pressure	☐	Thyroid Problems
☐	Bleeding Problems	☐	High Cholesterol	☐	Tuberculosis
☐	Cancer, Type:	☐	Kidney Disease, Type:	☐	Other:
☐	Diabetes/High Blood Sugar	☐	Liver Disease, Type:	☐	Other:
☐	Epilepsy/Seizures	☐	Migraines	☐	Other:

Annie Barseghian MD

800 Fairmount Ave, Suite 210
Pasadena CA 91105

Name:			Date:
PREVENTATIVE CARE			
Vaccinations With Date: (i.e. Flu, Hepatitis A/B, Pneumococcal) **1.**		**2.**	
3.		**4.**	
WOMEN		**MEN**	
Colonoscopy Last Date:	**Have you ever had an abnormal result? If so, please indicate date:**	**Colonoscopy Last Date:**	**Have you ever had an abnormal result? If so, please indicate date:**
Mammogram Last Date:	**Have you ever had an abnormal result? If so, please indicate date:**	**Prostate Exam Last Date:**	**Have you ever had an abnormal result? If so, please indicate date:**
Breast Exam Last Date:	**Have you ever had an abnormal result? If so, please indicate date:**	**PSA Level Checked Last Date:**	**Have you ever had an abnormal result? If so, please indicate date:**
PAP/Pelvic Exam Last Date:	**Have you ever had an abnormal result? If so, please indicate date:**		
Last Menstrual Period:	**Pregnancies:** / **Deliveries:**		
Current Form of Birth Control if Sexually Active:		**Current Form of Birth Control if Sexually Active:**	

LIFESTYLE			
Exercise:	**Frequency:**	**Duration: (in Minutes)**	**Type:**
Smoking Status:	**Frequency: (in Packs)**	**Duration: (in Years)**	**Past Attempts to Quit:**
Alcohol:	**Frequency:**	**Duration:**	**Type:**
Drug Use:	**Frequency:**	**Duration:**	**Type:**

CURRENT MEDICATIONS INCLUDING SUPPLEMENTS, WITH DOSAGE AND FREQUENCY	
1.	**2.**
3.	**4.**
5.	**6.**

800 Fairmount Ave, Suite 210
Pasadena CA 91105

Annie Barseghian MD

The following outline of financial responsibilities and consent policies have been established to assist us in providing the highest quality medical care and outline possible disclosures of health information for treatment, payment, and patient healthcare options.

Insurance: It is your responsibility to know and understand your coverage and benefits. As a courtesy, we file your insurance forms from our office. Please make sure your insurance and demographic information is kept up to date with our office. This includes any change of information such as address, phone numbers, and insurance changes. If the patient is not the policy holder on the insurance, we require the policy holder's full name, date of birth, social security number, and relationship to the patient to file all claims. Patients are responsible for all fees that are not covered by insurance, including co-payments, coinsurance, deductibles and non-covered services or items received. At every visit, please make sure you have all insurance card(s) and photo identification as well as any other forms that may assist us in processing your claims correctly.

No Insurance: If you are not covered by insurance at the time of service, please be advised that you will be responsible for all charges incurred at the time of service. Cash, PayPal, or credit card is accepted.

Returned Check: There will be a thirty dollar ($30.00) charge assessed for any check returned by your bank for any reason.

Collections: Accounts that are not paid within sixty (60) days from the date of service may be sent to our collections department. If acceptable terms cannot be reached to satisfy the past due balance, the patient may be dismissed from our practice.

Medical Records: We will provide a digital or analog copy of your medical records upon request for a twenty-five dollar ($25.00) administrative fee. You will be required to sign a medical record release form and pay the medical record fee in full prior to having your medical records copied. Please allow up to one (1) week for this request to be processed.

Dismissal Process: There are several reasons that a patient may be dismissed from our practice. A few reasons are as follows:

- Failure to keep scheduled appointments
- Being verbally abusive or physically abusive to staff
- Failure to meet financial obligations

All medical forms: $ 25.00 fee. Please allow 3-5 days for completion.

A certified letter will be sent to your last known address notifying you that you are being dismissed from Dr. Barseghian practice. If you have a medical emergency within thirty (30) days of the date of the letter, Dr. Barseghian see you. After the thirty (30) days, you will no longer be seen Annie Barseghian MD or her practice. A copy of your medical record may be forwarded to your new doctor after a formal request is made and appropriate fees are paid.

Patient Acknowledgement:

I,_____(print name) have read and agree to the Patient Financial Responsibilities and Policies.

I agree to pay at the time of service. I also understand that Annie Barseghian MD reserves the right to dismiss patients that fail to keep their accounts current after reasonable attempts to collect payments have been made. I further agree to pay all reasonable costs and late fees should my account be turned over to collections. I understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examinations, and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

Patient Signature (Date)

Annie Barseghian MD

800 Fairmount Ave, Suite 210
Pasadena CA 91105

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: Procedures and Applicable Law: A demand for arbitration must communicate in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in once proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days, or signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is Effective as of the date of first medical services.

Patient Initials: _____

If any provision if this arbitration agreement is held invalid of unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THE CONTRACT.

Physician Signature	Patient Signature (Date)
Annie Barseghian MD	
Name of Physician	Name of Patient

A signed copy of this document is to be given to Patient. Original is to be filed/scanned in Patient's medical records.

HIPAA Notice of Privacy Practices

Annie A. Barseghian, M.D.
Family Medicine
800 Fairmount Ave, Suite 210
Pasadena CA 91105

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.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health services.

1. Uses and Disclosures of Protected health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement. Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature_____ Date_____

visit today, please let us know how we can improve.

Annie A. Barseghian MD
Family Medicine
800 Fairmount Ave, Suite 201
Pasadena CA 91105
(626) 381-9599

EMAIL CONTRACT

Dr. Annie A. Barseghian occasionally will be sending information that may contain protected, privileged, and highly confidential medical, personal and health information (PHI), which may include labs/imaging/handouts, and legal information via email. **Please understand that this information may not be entirely secure.** The information transmitted is the property of Dr. Annie Barseghian and is intended only for the use of the individual or entity to which it is addressed as it may contain confidential and/or privileged material. Any review, transmission, discussion, dissemination or other use of, or taking any action in reliance upon, the information sent by persons or entities other than the intended recipient(s) is prohibited. If you receive the information in error, please contact the sender at healthmatters@barseghianmd.com or call (626) 381-9599 immediately and **confidentially** destroy and/or delete the information that was sent in error.

At any time, you may notify Dr. Annie A. Barseghian if you do not want PHI via email, or if there is certain information that you would prefer not to be sent via email.

Please check ☐ if you have reviewed and agree to terms of the HIPAA Policies.

Pleaes check ☐ if you reviewed and agree to terms of the Office Policies.

Please check ☐ if you have reviewed and agree to the terms of the Email Contract

_____ _____

Patient Signature/Guardian: Date:

_____ _____

Name of person filling out this form: Relationship to patient: