NEW PATIENT INFORMATION

DEBORAH BEUTLER, M.D.
INTERNAL MEDICINE
675 S. Arroyo Parkway Suite 110
Pasadena, CA 91105
626-243-5211

We are delighted to welcome you to our practice and are pleased that you have selected our office for your medical care. Prior to your first visit, please complete the following forms and bring them with you to your appointment. If you have any questions about the forms or are unsure of how to answer an item please leave it blank and we will help you complete those questions during your visit.

FORMS

_____ Patient Information Form

_____ Health Questionnaire Form

_____ Medical Records Request Form

_____ HIPAA Notice of Privacy Practices

In addition to the 4 completed forms, please bring:

_____ **I**nsurance cards—for primary and secondary insurance carriers.

_____ A Photo ID

OTHER IMPORTANT PAYMENT INFORMATION:

(ALL PRIVATE INSURANCE, MEDICARE & PPO PLANS)

If you have PPO insurance, you will be responsible in full for any portion of the bill not covered by your insurance company. With this understanding, you may either pay in full at the time of your visit and then be reimbursed later for the amount we receive from the insurance company OR, if you prefer, we can bill your insurance first and bill you later for anything not covered after we receive their payment.

If you have any questions, please contact our office at 626-243-5211.

PATIENT INFORMATION FORM

PATIENT INFORMATION Minor Single Married Divorced Widowed

Last Name:_____ First:_____ M.I._____ Sex: M F

Social Security #_____ Date of Birth: _____ Age:_____

Address:_____ City:_____ State:_____Zip:_____

Home # _____Cell #_____Email_____

Name of Employer:_____Phone:_____

POLICY HOLDER (If different from Patient)

Last Name:_____ First:_____ M.I._____ Sex: M F Social

Security #_____ Date of Birth:_____ Driver's License #_____

Address:_____Home #:_____Cell #:_____

Name of Employer:_____Phone:_____

SPOUSE INFORMATION (If different from above)

Last Name:_____ First:_____ M.I._____ Sex: M F Social

Security #:_____ Date of Birth:_____Driver's License #:_____

Address:_____ Home#_____Cell #:_____

GENERAL INFORMATION

Previous Physician Name:_____Phone:_____

Nearest Relative (not living with you) _____Phone:_____

Incase of Emergency Notify:_____Phone_____Relationship:_____

INSURANCE INFORMATION:

Who referred you to our office? (Doctor/Friend/Phonebook)_____Phone:_____

Primary Insurance Plan:_____Policy Holder's Name:_____

ID#:_____Group#_____Phone:_____

Secondary Insurance Plan:_____Policy Holder's Name:_____

ID#:_____Group#:_____Phone:_____

Financial Agreement: I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all cost of collection, and attorney's fees. **Assignment of Benefits:** I hereby give lifetime authorization for payment to be made directly to any assisting Physician, for services rendered. I hereby authorize this Healthcare Provider to release all information necessary to secure payment of benefits. I have received and read the Notice of Privacy Practices which advises how you may use and disclose protected information. I agree to the uses and disclosure of my Information for purposes of treatment, payment and practice operations.

HIPAA INFORMATION: Instructions for the office when returning phone calls or reminding you about appointments.

I authorized the office to contact me at: [ ] Home [ ] Work [ ] Cell and May leave messages at: [ ] Home [ ] Work [ ] Cell
I authorize the office to leave detailed messages about appointments/phone calls: [ ] YES [ ] NO If you prefer us to leave messages with a specific individual please list them here: 1._____ 2._____

Patient (or Parent/Guardian) Signature:_____Date:_____

Deborah Beutler M.D.
675 S. Arroyo Parkway
Suite 110
Pasadena, CA 91105
626-243-5211

Payment Policy:

Thank you for choosing me as your primary care provider. I am committed to providing you with quality and affordable health care. Because some patients have had questions regarding patient and insurance responsibility for services rendered, I have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance**. We bill all PPO insurance companies and medicare. Since we are not contracted with any PPO insurance, other than for Huntington Hospital employees, you will be responsible for any portion of your bill not covered by your insurance company. With this understanding, you may either pay in full at the time of your visit and then be reimbursed later for the amount we receive from the insurance company OR, if you prefer, we can bill your insurance first and bill you later for anything not covered after we receive their payment.

2. **Non-covered services**. Please be aware that some of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You will be responsible for payment for these services.

3. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current valid insurance to provide proof of insurance if we are to bill insurance on your behalf.

4. **Claims submission**. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

5. **Coverage changes**. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 60 days, the balance will automatically be billed to you.

6. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that full payment must be received within 20 days. Partial payments will not be accepted unless otherwise negotiated. We reserve the right to submit your account to a collection agency if the account is not paid. If this occurs, an additional delinquency/collection fee of 35% will be added.

7. **Missed appointments**. Our policy is to charge for missed appointments not canceled at least 24 hours in advance beginning with the second missed appointment or the first new patient appointment. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment. If you would like us to leave a phone message reminding you of an appointment please check the appropriate box at the bottom of the Patient Registration Form.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date

Deborah Beutler, M.D. form 20150625

Original Date:
Dates Revised:

DEBORAH BEUTLER, M.D.

HEALTH HISTORY QUESTIONNAIRE

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

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Shingles
	☐ Influenza	☐

List any medical problems that other doctors have diagnosed (please circle)

High Blood pressure	Lung disease	cancer	stomach ulcer
Diabetes	kidney problem	broken bone	Dementia
Heart disease	liver disease	arthritis	chronic pain
High cholesterol	stroke	thyroid disease	

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

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

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)			☐ moderate exercise	
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			☐ regular exercise	
	Do you drink alcohol? ☐ Yes ☐ No		Do you use tobacco? ☐ Yes ☐ No		
Tobacco					
		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No

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*		

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**

WOMEN ONLY		
Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Date of last pap and rectal exam?		
MEN ONLY		
Date of last prostate and rectal exam?	☐ Yes	☐ No

OTHER PROBLEMS

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

☐ Neurology: Headaches, Dizziness, Confusion	☐ Gastroenterology: Acid Reflex, Bloating, Abd. Pain, Abd. Swelling	**Recent changes in:** (Please Explain)
☐ Muscle: Cramps, Stuffiness, Swelling	☐ Respiratory: Dry mouth, sputum, Persistent cough	☐ *Appetite:*
☐ Skin rash, mole, Lumps	☐ Chest/Heart: pain, palpitation	☐ *Weight:*
☐ Head/Neck pain ,swelling,	☐ Back/joint pain, stiffness, Swelling	☐ *Energy level:*
☐ Ears pain, discharge, ringing	☐ Intestinal constipation, diarrhea, Change in stool	☐ *Ability to sleep:*
☐ Nose: congestion, Bleeding, Loss of Smell	☐ Urinary Frequent, Uncontrolled, Burning Sensation	☐ *Physiological:*
☐ Throat: pain, swelling, Discharge	☐ Brain: Weakness, Numbness, Memory Loss	☐ *Other pain/discomfort:*
☐ Lungs: difficulty breathing, wheezing	☐ Circulation Leg pain, Numb limbs, Varicose veins	

DEBORAH BEUTLER, M.D.
INTERNAL MEDICINE
675 S. Arroyo Parkway Suite 110
Pasadena, CA 91105
626-243-5211

HIPAA Notice of Privacy Practices

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 care 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 care 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 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 an office procedure may require that your relevant protected health information be disclosed to the health plan to obtain approval for the visit.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your provider'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 provider. We may also call you by name in the waiting room when your provider 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 provider is not required to agree to a restriction that you may request. If your provider 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 to 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.**

I, _____ have received a copy of this Policy.
Print Patient Name

Patient Signature _____ Date _____

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize

_____
Name of physician or hospital

_____
Address

_____

_____
Phone

_____
Fax

to release all healthcare information of the patient named above to:

Deborah Beutler, M.D.
675 S. Arroyo Parkway
Suite 110
Pasadena, CA 91105
626-243-5211
fax: 626-498-2327

Yes No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Definition: *Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.*

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.