



ANDREW S. FLOREA M.D., INC.
Specializing in Otolaryngology-Head and Neck Surgery (ENT)
Voice and Swallowing Disorders, and Facial Plastic Surgery

Dear Sir or Madam,

You have an appointment scheduled with Dr. Andrew S. Florea on _____ at _____ am / pm at our Redland's office. If you are unable to be at your appointment or if this is appointment date/time is not correct, please call the office at (909) 335-3000.

In order to make your appointment run more smoothly, please bring/fill out the following:

- **FORMS:** Please fill out the enclosed forms and bring them with you for your appointment.
- **INSURANCE CARD:** (primary and secondary cards). We will need to make copies of your cards.
- **TEST RESULTS:** (blood work, biopsy, MRI, CT, X-Ray, Ultrasound, PET Scan). We may not be able to get these results the day of your appointment so please get copies of these ahead of time from your primary care physician or the facility where the test was performed.
- **FILMS:** In addition to the reports, please bring in the actual films or a disk (CD-ROM) of the imaging study for the doctor to review as well.
- **CO-PAYS:** (HMO's, PPO's and other insurances that require a co-pay). All co-pays must be paid at the time of your visit. There will be an additional processing charge for any uncollected co-pays.
- **REFERRALS:** Please ensure that your referral (if required by your insurance plan) has been obtained or put into the system by your primary care physician's office **before** your appointment. If you do not have a referral on the day of your appointment, it may be rescheduled.
- **MEDICATIONS:** Please bring in a complete list of current medications.

Please be aware that it is your responsibility to know the terms of your insurance plan. We participate with numerous insurance plans, which have very different policies. Our office staff cannot be responsible for knowing your specific plan's policies.

Please keep in mind that you will be responsible to furnish all necessary information for the physician to review at the time of your visit, without this information your appointment may be cancelled and/or rescheduled for a later date. Please arrive promptly to your schedule appointment.

Thank you and we look forward to meeting you and taking care of you.

255 Terracina Blvd., Ste. 205-C Redlands, CA 92373



ANDREW S. FLOREA M.D., INC.
NEW PATIENT INFORMATION

Last Name First Name M.I.

Address City State Zip

Soc. Sec. # Age DOB Phone #

CA D.L.# Marital Status: M S W D Sep. Gender: Male Female

Employer Occupation Phone #

Address City State Zip

PRIMARY INSURANCE

Name Policy # Phone #

Address City State Zip

SECONDARY INSURANCE (if applicable)

Name Policy # Phone #

Address City State Zip

INSURED PARTY INFORMATION IF DIFFERENT THAN ABOVE

Name Phone #

DOB Soc. Sec. # Relation

Address City State Zip

Ins. Co. Name Policy # Phone #

Address City State Zip

FRIEND OR RELATIVE IN THE AREA

Name Phone #

Address City State Zip

ANDREW S. FLOREA M.D., INC.
255 TERRACINA BLVD., STE. 205-C
REDLANDS, CA 92373

Financial Agreement: I hereby authorize you to make payments directly to Dr. Andrew S. Florea for all basic and major medical expenses. I fully understand I am financially responsible for any balance.

Medical Records: Authorization is hereby granted for the release of any information required to process my medical claims. A copy of this authorization is as valid as the original.

Consent for Treatment: I, the undersigned, hereby consent to the administrator of and performance of all diagnostic procedures and treatment, which, in the judgment of my physician, may be considered necessary or advisable. I further agree that if I decide to leave without receiving treatment or without the consent of my attending physician, the physician will not be liable for the consequences of such decision.

Patient or Responsible Party Signature

Date



ANDREW S. FLOREA M.D., INC.
PRACTICE FINANCIAL POLICY

We are committed to providing all our patients with the best possible medical care. If you have medical insurance, we are anxious to help you receive your maximum allowable plan benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

ALL PATIENTS: The patient is responsible for all services rendered regardless of insurance coverage. The full responsibility of payment rests with you, the patient or responsible party.

CASH PATIENTS: All services rendered on a cash basis must be paid in full at the time of service.

PRIVATE INSURANCE: We must have accurate, complete insurance information at the time of service. If you cannot supply us with all the necessary billing information, your account will be handled the same as a cash patient. Any deductible and co-payment amounts are due at the time of service.

MEDICARE: We must have a copy of your Medicare card and any secondary insurance(s). We do accept assignment on Medicare claims, which means that you will be responsible only for your deductible and 20% of allowed charges. There are certain procedures and supplies, which are NON-COVERED services for Medicare patients. If you need such services you will be informed that they are NON-COVERED and if you still wish to receive such services in this office they will be on a cash basis at the time of service.

IF AT ANY TIME YOU SHOULD EXPERIENCE FINANCIAL HARDSHIP, PLEASE MAKE THIS OFFICE AWARE OF THE SITUATION. WE ARE ALWAYS WILLING TO MAKE SPECIAL ARRANGEMENTS FOR THOSE PATIENTS WHO NEED EXTRA HELP. IF YOU NEED TO MAKE ARRANGEMENTS, PLEASE ASK TO SPEAK WITH THE BILLING SUPERVISOR OR MANAGER.

I have carefully read and understand all of the above and accept, approve, and agree to **Andrew S. Florea M.D.** Practice Financial Policy.

Patient or Responsible Party Signature

Date



ANDREW S. FLOREA M.D., INC.

PATIENT MEDICAL HISTORY

PATIENT'S NAME: _____ DATE: _____

D.O.B: _____ AGE _____ SEX _____ HT. _____ WT. _____

SURGICAL HISTORY: _____

PAST MEDICAL HISTORY:

Major Illness: _____

Major Injuries: _____

Positive TB: Yes _____ No _____ When? _____

REVIEW OF SYSTEMS:

<p>General</p> <p>Yes No Weakness or Fatigue</p> <p>Yes No Recent Weight Loss</p> <p>Eyes</p> <p>Yes No Blurred Vision</p> <p>Yes No Double Vision</p> <p>Ear, Nose, Mouth and Throat</p> <p>Yes No Trouble Hearing</p> <p>Yes No Tinnitus or Ringing in Ears</p> <p>Yes No Ear Pain</p> <p>Yes No Ear Infection or Drainage</p> <p>Yes No Dizziness, Vertigo or Unsteadiness</p> <p>Yes No Stuff Nose</p> <p>Yes No Sinus Trouble</p> <p>Yes No Frequent Nose Bleeds</p> <p>Yes No Frequent Sore Throats</p> <p>Yes No Pain Near Teeth or Mouth</p> <p>Yes No Hoarseness or Voice Change</p> <p>Yes No Difficulty with Swallowing</p> <p>Yes No Lump in Neck</p> <p>Yes No Pain in Neck</p> <p>Cardiovascular</p> <p>Yes No Heart Trouble</p> <p>Yes No Palpitations</p> <p>Yes No High Blood Pressure</p> <p>Respiratory</p> <p>Yes No Cough</p> <p>Yes No Asthma or Wheezing</p> <p>Yes No Shortness of Breath</p> <p>Hematologic</p> <p>Yes No Easy Bruising or Bleeding</p> <p>Yes No Anemia</p>	<p>Allergic</p> <p>Yes No Hay fever or Dust/Mold Allergy</p> <p>Yes No Food Sensitivity or Intolerance</p> <p>Yes No Chemical Sensitivity</p> <p>Gastrointestinal</p> <p>Yes No Heartburn or Acid Reflux</p> <p>Yes No Nausea or Vomiting</p> <p>Yes No Diarrhea</p> <p>Yes No Ulcers</p> <p>Yes No Frequent Use of Antacids</p> <p>Genitourinary</p> <p>Yes No Kidney Problems</p> <p>Musculoskeletal</p> <p>Yes No Joint Pains or Stiffness</p> <p>Integumentary</p> <p>Yes No Skin Rashes</p> <p>Neurological</p> <p>Yes No Headaches</p> <p>Yes No Numbness in Face, Legs, or Arms</p> <p>Yes No Seizures</p> <p>Yes No Weakness in Arms or Legs Yes</p> <p>Yes No Blackouts or Fainting</p> <p>Yes No Trouble Speaking</p> <p>Yes No Confusion or Memory Loss</p> <p>Psychiatric</p> <p>Yes No Nervousness or Increased Stress</p> <p>Yes No Sleep Problems</p> <p>Yes No Snoring</p> <p>Yes No Excessive Moodiness or Worry</p> <p>Endocrine</p> <p>Yes No Thyroid Problems</p> <p>Yes No Diabetes</p>
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FAMILY HISTORY:

Lung Disease	Yes _____	No _____	Who? _____
Heart Disease	Yes _____	No _____	Who? _____
Diabetes	Yes _____	No _____	Who? _____
Cancer	Yes _____	No _____	Who? _____
Blood Pressure	Yes _____	No _____	Who? _____
Positive TB	Yes _____	No _____	Who? _____

SMOKE: Yes _____ No _____ Quit? Yes _____ No _____ If so, when? _____

Cigarettes	_____	How Long	_____	# Packs	_____	# Cigs	_____
Cigar	_____	How Long	_____	# Packs	_____	# Cigs	_____
Pipe	_____	How Long	_____	# Packs	_____	# Cigs	_____

ALCOHOL USE: Yes _____ No _____ Quit? Yes _____ No _____ If so, when? _____

Frequently _____ Social _____ Rarely _____

DRUGS: Yes _____ No _____
Type: _____ Quit: Yes _____ No _____ If so, when? _____

PLEASE LIST ANY PRIOR (MOST RECENT) HOSPITALIZATIONS: _____

REASON FOR ENCOUNTER: _____

REFERRING PHYSICIAN: _____

PATIENT CONSENT FORM & NOTICE OF PRIVACY PRACTICES

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining authorization and/or payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operation, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

“I acknowledge that I have received a copy of the Notice of Privacy Practices from Andrew S. Florea M.D.”

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____ Date: _____

ANDREW S. FLOREA M.D., INC.
255 Terracina Blvd., Ste. 205-C
Redlands, CA 92373
Phone: 909-335-3000
Fax: 909-335-3001

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

- Home Telephone # _____
- Leave message with detailed information.
- Leave message with call back number only.

- Work Telephone # _____
- Leave message with call back number only.

- Written Communication
- Mail to my home address.
- Mail to my work/office address.
- Fax to this number: _____

- Other _____

I authorize Andrew S. Florea M.D. and/or staff to disclose *PHI* to the following members of my family or person/s responsible for my healthcare (check all that apply):

- Spouse: Name _____
- Daughter/s: Name/s _____
- Son/s: Name/s _____
- Extended Care Facility _____
- Other: _____

Print Name

Date of Birth

Patient Signature

Date



ANDREW S. FLOREA M.D., INC.
MEDICAL RECORDS RELEASE AUTHORIZATION

TO: ANDREW S. FLOREA M.D., INC.
255 TERRACINA BLVD., STE. 205-C
REDLANDS, CA 92373
PHONE: 909-335-3000
FAX: 909-335-3001

I HEREBY REQUEST A COPY OF THE FOLLOWING REPORTS:

CONSULT _____ LABS _____
BILLING _____ X-RAY _____
OTHER _____

PLEASE RELEASE THE ABOVE REQUESTED RECORDS TO:

AUTHORIZED SIGNATURE _____
PRINT SIGNATURE _____
DATE OF BIRTH _____
SOCIAL SECURITY # _____
DATE SIGNED _____



ANDREW S. FLOREA M.D., INC.
REQUEST FOR RELEASE OF MEDICAL RECORDS

TO: _____

Phone # _____
Fax # _____

I HEREBY REQUEST A COPY OF THE FOLLOWING REPORTS:

CONSULT _____ LABS _____
TREADMILL _____ PROGRESS NOTES _____
X-RAY _____ EKG _____
OTHER _____

PLEASE RELEASE THE ABOVE RECORDS TO:

ANDREW S. FLOREA M.D., INC.

255 Terracina Blvd., Ste. 205-C
Redlands, CA 92373
Phone # (909) 335-3000
Fax # (909) 335-3001

Date: _____

Patient's Name (Please Print): _____

Patient's Date of Birth: _____

Patient's Signature: _____

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

Under the health insurance portability & accountability Act of 1996 (HIPAA), all medical records and other individually identifiable health information of which we have knowledge must be kept confidential. All personal health information used by us or disclosed by us is covered by this Act regardless of whether this personal health information is in electronic, oral or on paper form. Several new rights are granted to patients under this Act, allowing control over how your personal health information is used, how you can access it, and in some cases amend it.

We are required by law to maintain the privacy of your personal health information and to provide you with notice of our legal duties and privacy practices with respect to your personal health information.

We may be assessed a penalty for any misuse or unauthorized disclosures of your personal health information as regulated by HIPAA.

This notice of privacy practices is effective on **APRIL 15, 2003**.

We are bound to abide by the terms of this notice and reserve the right to make revision to this policy. Should revision be made, you will be notified in writing, and a copy of the revised policy will be made available at your request.

You will be asked to sign a consent form authorizing us to use and disclose your personal health information only for the following purposes, as defined under the Act:

- Treatment means the provision, coordination, or management of health care and related services by one or more healthcare provider, including the coordination or management of health care by a healthcare provider with a third party; consultation between healthcare providers relating to a patient; or the referral of a patient for health care from one healthcare provider to another. An example of this would be a primary care physician to a pulmonary specialist.
- Payment means obtaining reimbursement for the provision of health care; determinations of eligibility or coverage; billing; claims management; collection activities; justification of charges; and disclosure to consumer reporting agencies; protected health information relating to the collection of reimbursements (only certain information may be disclosed). An example of this would be submitting your bill for health care services to your insurance company.
- Health care operations are any activity related to covered functions in which we participate in the function of our offices, such as conducting quality assessment activities; protocol development; case management and care coordination; auditing functions; business management and general administrative activities, including implementation of this regulation; customer service evaluations; resolution of grievances; fundraising; and marketing for which authorization is not required. An example of this would be evaluating customer service given to patients.

We may, without prior consent use or disclose your personal health information to carry out treatment, payment of healthcare operations:

- Directly to you at your request;
- In an emergency treatment situation, if we attempt to obtain such consent as soon as reasonably practicable after the delivery of such treatment, if we are required by law to treat you and attempts to obtain consent are unsuccessful, or if we attempt to obtain consent but are unable, due to barriers of communication, but we determine in our professional opinion that treatment is clearly inferred from the circumstances;
- Pursuant to and in compliance with an authorization signed by you; and
- Provided that you are informed in advance of the use and disclosure and have the opportunity to agree to or prohibit or restrict the use or disclosure. This may be an oral agreement between us and may include a directly maintained at our facility containing specific information allowed by this Act.

We may de-identify your personal health information by using codes or removing all individually identifiable health information.

All other uses and disclosure will be made only upon securing a written authorization form signed by you. You have the right to revoke this authorization, at any time, upon written notice and we will abide by that request. However, exception would be any actions already taken, relying on your authorization, prior to revocation of notice.

We may contact you to provide appointment reminders or to inform you about treatment alternatives or other health related benefits or services that may be of interest to you. We may also contact you for fundraising purposes.

Under HIPAA, you have the following rights with respect to your protected health information:

- You have the right to request restrictions on certain uses and disclosures of protected health information, concluding restrictions placed upon disclosure to family members, close personal friends, or any other person you may identify. We are, however, not required to agree with a requested restriction;
- You have the right to receive confidential communications of your protected health information, either directly from us or from us by alternative means or from alternative locations;
- You have the right to inspect and copy your protected health information;
- You have the right to amend protected health information, however, this request may be denied under certain circumstances;
- You have the right to receive an accounting of disclosures of your protected health information made by us in the six years prior to the date of the accounting request; and
- You have the right to obtain a paper copy of this notice from us, even if you have already agreed to receive the notice electronically

If you feel your privacy rights or the provision of this notice of privacy policies has been violated, you have the right to file a formal written complaint. This complaint should be addressed either to the Privacy Officer at our office, or directly to the Department of Health & Human Services and/or the Office of Civil Rights. Both addresses appear below. You will not be retaliated against, in any way, for filing a complaint.

For more information about HIPAA or to file a complaint, contact:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Ave., S.W.
Washington D.C. 20201
(202) 619-0257
Toll Free (877) 696-6775

Please Contact us for more information:

PRIVACY OFFICER
OFFICE MANAGER
Tel #: (909) 335-3000



ANDREW S. FLOREA M.D., INC.
Specializing in Otolaryngology-Head and Neck Surgery (ENT)
Voice and Swallowing Disorders, and Facial Plastic Surgery

Patient/Physician Arbitration Form

- 1) 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 lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, this arbitration agreement, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.
- 2) ALL CLAIMS MUST BE ARBITRATED. I understand that all claims for damages arising from medical services rendered by Andrew S. Florea M.D., Inc. and/or associate or substitute physicians, nurses or employees must be arbitrated. This includes any claim of a spouse, heir, child (born or unborn), or other successor in interest to any such claim.
- 3) ARBITRATION PANEL. Within 30 days of a demand to arbitrate a dispute, which must be made in writing, the parties shall agree on three (3) medical arbitrators. Each party will bear the costs for their own legal counsel, and other expenses incurred for their own benefit, as well as pro rata share of arbitration expenses.
- 4) APPLICABLE LAW. I agree that the California Code of Civil Procedure relating to arbitration shall apply without any exception.
- 5) REVOCATION OF THE AGREEMENT. This agreement may be revoked and cancelled by written notice delivered to Andrew S. Florea M.D., Inc. within 30 days of the signing of this agreement. If notice of revocation of this agreement is not received within 30 days of its signing, the right to cancel the agreement is forever waived.
- 6) RETROACTIVE EFFECT. If the signing party intends this agreement to cover all services rendered before the date of the signing of this agreement (including, but not limited to, prior consultations or treatment), the signing party must initial here:

- 7) ACKNOWLEDGEMENT. By signing this agreement, the signing party acknowledges he/she discussed to his/her satisfaction any questions he/she may have had regarding the arbitration agreement with Andrew S. Florea M.D., Inc., an associate physician, physician assistant, nurse practitioner, or authorized legal representative of Andrew S. Florea M.D., Inc.
- 8) If any provision of this arbitration agreement should be held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.



ANDREW S. FLOREA M.D., INC.
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Voice and Swallowing Disorders, and Facial Plastic Surgery

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 THIS CONTRACT.

Patient Signature (or Guardian if minor): _____

Patient Name: _____ Date: _____

If signed by someone other than the patient, indicate the relationship:

Physician's agreement to arbitrate: In consideration of the foregoing execution of the Patient/Physician Arbitration Agreement, Andrew S. Florea M.D., Inc. and staff likewise agree to be bound by the terms set forth in this agreement.