ATTUNE HEALTH

Dr. Venuturupalli ☐
Dr. Lee ☐

Dr. Scaramangas ☐
Dr. Wallace ☐

PATIENT REGISTRATION FORM

PATIENT INFORMATION

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

Preferred Name (Nickname): _____ Maiden Name: _____

Date of Birth: _____ Sex: _____ Social Security#: _____ Marital Status: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Authorized to text?: Yes ☐ No ☐

Work Phone: _____ Email: _____ Authorized to email?: Yes ☐ No ☐

Pharmacy Name/Address/Phone: _____

Employer Name: _____ Occupation: _____

Emergency Contact Name and Phone Number: _____ Relationship: _____

Primary Care Physician: _____ Phone/Fax: _____

How were your referred to the office?: _____

Would you be interested in hearing about a research study?: _____

INSURANCE INFORMATION

PRIMARY INSURANCE:

Insurance Name: _____ Relationship to Policy Holder: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____ Sex: _____

Policy/ID #: _____ Group #: _____ Effective Date: _____

Claim Address & Phone Number: _____

SECONDARY INSURANCE:

Insurance Name: _____ Relationship to Policy Holder: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____ Sex: _____

Policy/ID #: _____ Group #: _____ Effective Date: _____

Claim Address & Phone Number: _____

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AUTHORIZATION, ASSIGNMENT, AND RELEASE

By signing below, I certify all information provided is true and correct to the best of my knowledge. I authorize payment directly to this physician practice for all medical services otherwise payable to me under terms of my insurance (if applicable). I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. I hereby authorize the release of medical information including complete medical records, test results, and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred from or to for treatment. A photocopy of this authorization shall be considered as effective and as valid as the original.

Patient Signature: _____ **Date:** _____

PATIENT MEDICAL PROFILE QUESTIONNAIRE

Date: _____ Active MyCSLink User: Yes No

Patient Name: _____

What is the special problem(s) or symptom(s) that brings you here for an appointment?

_____

_____

_____

_____

_____

Number of Children: _____. Please list their ages: _____
Occupation: _____
Highest Level of Formal Education: _____

Family History:

Father: Living □ Deceased □ Age of Death: _____ Medical History:	Father: Living □ Deceased □ Age of Death: _____ Medical History:

Do you have any family members with autoimmune diseases? If yes, please list below:

_____

_____

_____

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Please list all medications that you take regularly (prescription and nonprescription) with dosages: (You may instead bring in a written medication list)

Medication	Dosage	Medication	Dosage
1.		9.	
2.		10.	
3.		11.	
4.		12.	
5.		13.	
6.		14.	
7.		15.	
8.		16.	

Please list any operations you have had:

Type of operation	Year	Hospital

Please list any non-surgical hospitalizations:

Reason for hospitalization	Year	Hospital

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All information on this questionnaire will be kept confidential. It cannot be photocopied without your written consent.

Autoimmune	**YES**	**NO**
1. Have you experienced dry eyes for 3 months or longer?		
2. Have you experienced dry mouth for 3 months or longer?		
3. Have you had a lot of hair fall out recently?		
4. Do you get oral ulcers?		
5. Are you troubled by stiff or painful joints?		
6. Are your joints ever swollen?		
7. Do you often get a rash on your cheeks?		
8. Are you sensitive to sunlight?		
9. Do your fingers turn different colors in cold weather? (Raynaud's)		
10. Have you ever had pleurisy or pericarditis?		
11. Have you ever been told that you had protein in your urine?		
12. Have you ever had a positive blood test for ANA (antinuclear antibody)? Or any abnormal blood test? If so, specify.		
Constitutional		
13. Have you recently lost weight?		
14. Do you often feel exhausted or fatigued?		
15. Do you frequently run low-grade fevers?		
ENT		
16. Have you had intermittent swelling of your salivary glands?		
17. Is it difficult or painful for you to swallow?		
Skin	**YES**	**NO**

18. Do you have any skin conditions? If yes, please list below.		
19. Have you ever been told you have psoriasis?		
Respiratory		
20. Do you wheeze or gasp to breathe?		
21. Do you wheeze or feel short of breath?		
22. Do you have sleep apnea?		
Musculoskeletal		
23. Do you have osteoporosis?		
24. Have you been told by a doctor that you have Fibromyalgia? Myofascial Pain Syndrome)?		
25. Are you bothered by lower back pain?		
26. Have you been diagnosed with gout or pseudogout?		
Cardiovascular		
27. Do you ever get pain or tightness in your chest?		
28. Are you troubled by swollen feet or ankles?		
29. Do you have high blood pressure (hypertension)?		
Psychiatric		
30. Have you ever desired or sought psychiatric help? If yes, for what?		
31. Do you ever have difficulty falling or staying asleep?		
32. Do you usually feel lonely or depressed?		
33. Do you have bipolar disorder?		
34. Do you have difficulty relaxing?		
Neurological		
35. Do you have frequent headaches?		
36. Is any part of your body numb?		
37. Are you troubled by dizzy spells or lightheadedness?		

	YES	NO
38. Have you ever had a seizure or a stroke?		
39. Do you have any visual changes?		
Gastrointestinal		
40. Are you troubled by heartburn?		
41. Do you easily become nauseated?		
42. Do you have gas or bloating?		
43. Have you been diagnosed with Crohn's or Ulcerative Colitis?		
44. Are bowel movements often loose?		
45. Are your bowel movements ever black or bloody?		
46. Are you often constipated?		
Hematologic		
47. Have you ever had low Vitamin B_{12}, low iron, or bone marrow disorder? If yes, please specify:		
48. Have you ever been treated for a blood clot with blood thinners?		
49 Have you ever had cancer of any kind? If yes, what kind? When and where were you diagnosed?		
50. Have you ever been told that you were anemic?		
51. Have you ever had low white blood cell count? If yes, do you have(check all that apply): a) Low iron, b)low B12, c)heavy periods, d)anemia of chronic disease e)bleeding ulcers, f)anemia due to medication g)hemolytic anemia, h)other,(specify)		
52. Have you ever had low platelets counts?		
53. Have you ever had idiopathic thrombocytopenia purpura (ITP)?		
54. Have you been told by a doctor that you have antiphospholipid syndrome?		

Allergy/Infection		**YES**	**NO**
55. If you are allergic to any medication or food, please list with reaction:			
56. Have you ever had Hepatitis?			
57. Have you ever had a positive skin test or blood test for TB?			
58. Do you get sick frequently?			
MISC			
59. Do you smoke cigarettes currently? Have you smoked in the past? If so, please specify duration of time (in years).			
60. Are you using birth control? If yes, what?			
61. Fill in the number of each of the following if applicable:			
Pregnancies	Children Born Alive		
Premature births	Stillbirths		
Abortions	miscarriages		

Is there anything important in your medical history that we did not ask which might be useful for the doctors to know?

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OFFICE POLICIES/AGREEMENT

Financial agreement - As the responsible party, you are responsible if your insurance company declines to pay for any reason. The patient or the responsible party must:

- Inform this office of the current address and phone number for the patient and the responsible party.
- Present all current medical insurance cards prior to each office visit.
- Pay any required copay at the time of the visit, as well as all previous balances due.
- Pay any additional amount owing within 30 days of receiving a statement from our office. (When the provider receives an explanation of benefits (EOB) from your insurance company, any amounts that you need to pay will be billed to you).
- **Collections** – The responsible party may be sent to collections after 90 days past due, and interest will be added.
- **Returned Checks** – If a payment is made on an account by check, and the check is returned for any reason, the responsible party will be responsible for the original check amount in addition to a $35 service charge.

Insurance – This office is only in network with Medicare, Blue Cross and Blue Shield PPO & EPO plans.

- **Out-of-network** - For out-of-network insurances, if our real time eligibility system cannot verify if your out-of-network deductible has been met, we will collect a PARTIAL payment towards your visit. Please be advised this is not the full amount of services rendered at the time of your visit. Please also be advised that you may be responsible for an increased deductible or co-insurance based on your insurance company's Explanation of Benefits. If you have no Out-of-Network benefits, you will be considered a cash pay patient, and all fees will be due at the time of service.
- **Medi-Cal/HMO** – This office is not contracted with any Medi-Cal, Medicaid and/or any Managed (HMO) plans whether it is in California or any other state. If your only insurance is Medi-cal/HMO, you will be considered a cash patient and all fees will be due at the time of service.

Late Policy – Our office allows a 15 minute grace period from the time you are requested to be in for your appointment. Past the 15 minutes, you may be given the option to wait for another appointment time on the same day if one is available, or you may be asked to reschedule your appointment.

Email Content - All of our patients will receive complementary Attune Health newsletters and related content by email.

❑ I am not interested in receiving Attune Health's complementary newsletter and/or related content.

No Show Policy – If you are unable to keep an appointment, our office requires at least 24 hour notice. You can cancel/reschedule an appointment by speaking to someone from the office in person or on the phone, or leaving a voicemail message. New patients will be charged $150 for a no show, follow up visits will be charged $75 for a no show, and infusion patients will be charged based on the amount of time your infusion generally takes ($150 per hour).

External prescription history – I authorize the provider I see to view my external prescription history via the MyChart service. I understand that this information may be needed to best assist with my care.

Prescription policy – I understand that my doctor will attempt to refill prescription request within 2 business days (Monday – Friday). Refill request may be done in person at my appointment, via phone or voicemail, via letter to my doctor's office, or through CS link. I understand I must allow adequate time to ask for refills before I run out of medicine, including enough lead time for us to prepare prescriptions for you to mail to a prescription service.

Narcotics policy - Due to increasing reports of abuse of narcotics, and the subsequent surveillance of the prescription practices of physicians by the state, this office normally will not prescribe continuous pain medication. I understand if I require strong narcotics on a continuous basis, I will be referred back to my Primary Care Physician or a Certified Pain Management Physician.

Prior Authorizations – I understand that some medications I may take will require a prior authorization. The authorization process can take up to 4 weeks and may be longer if the insurance denies and an appeal is needed. If multiple appeals are needed, charges may apply. In understand that a prescription card may be requested from me and may help with the authorization process.

Our doctors and staff truly appreciate your compliance and understanding to these policies so that we can continue to provide excellent medical care.

Print: _____

Signature: _____ **Date:** _____

ATTUNE HEALTH

PATIENT CONSENT TO NOTICE OF PRIVACY PRACTICES

In Accordance with the Health Insurance Portability and Accountability Act (HIPAA), you have been provided with our Notice of Privacy Practices that provides information about how we may use and disclose protected health information ("PHI") about you. The notice provides a more complete description of information uses and disclosures.

As part of your healthcare, we maintain health records that describe your health history, symptoms, examinations and test results, diagnosis, treatment and plans for future care or treatment. This information serves as a basis for planning your care and treatment; a means of communication among other health professionals who contribute to your care; a source of information for applying your diagnosis and healthcare information to bill third parties; a means by which a third-party payer can verify that services billed were actually provided; and a tool for routine healthcare operations such as assessing quality and reviewing the delivery of medical services.

You have the right to review our Notice before signing this consent. As provided in our Notice, the terms of our notice and/or privacy practices may change. If we change our Notice and/or privacy practices, we will provide you with a revised copy by mailing it to your then-current address.

You have the right to object to the use of disclosure of your health information. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of PHI about you for treatment, payment and healthcare operations in accordance with the Notice of Privacy Practices. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Initial {_____} I request the following restrictions to the use or disclosure of my health information:

_____

_____

I have received and read the Notice of Privacy Practices and Patient Individual Rights and consent to the use and disclosure of my health information for treatment, payment, and healthcare operations as described therein.

Signature: _____ **Date:** _____

ATTUNE HEALTH

NOTICE OF PATIENT INDIVIDUAL RIGHTS
8750 Wilshire Blvd., Suite 350, Beverly Hills, CA 90211

Pursuant to the health Insurance Portability and Accountability Act ("HIPAA"), this notice to you that with respect to your medical and health care records at this office, you have the following rights:

1. RIGHT TO ACCESS AND COPY INFORMATION.

In Accordance with 45 C.F.R. §164.524, you have the right to access and copy your own protected health information ("PHI") maintained in "designated record sets". A designated record set includes your medical records and billing records maintained in this office.
Our office is required to respond to your request for access and/or copying of your records within 30 days following receipt of a written request from you. If your records are not accessible on site in the office, we are required to respond within 60 days.
If for some reason we deny your request to access or copy your records, you may appeal that denial to the contact person/privacy officer at this office, whose name, phone number and address are listed below.

You may be charged a reasonable fee for costs associated with the copying of your records. These costs typically will be ten cents ($0.10) per page for standard reproduction of documents of a size 8 ½ by 14 inches or less and reasonable clerical costs incurred in locating and making the records available to be billed at the maximum rate of sixteen dollars ($16.00) per hour per person, computed on the basis of four dollars ($4.00) per quarter hour or fraction thereof and actual postage charges

2. RIGHT TO AMEND INFORMATION.

In accordance with 45 C.F.R. §164.526, you have the right to amend erroneous or incomplete PHI, unless the information was not created by our office, or the information is not in a "designated record set", or is accurate and complete, or would not be available for inspection under the previous section.
Our office is required to respond within 60 days, following receipt of a written request from you, by granting or denying your request. If we deny your request, you may file a statement of disagreement which will be included in your records. If you grant your request to amend the records, we will make the correction in all affected records, inform our business associates and others regarding the correction as needed and we will inform you when the correction has been made. Any corrections that may be made will conform to the medical practice model for amending medical records in order to retain the integrity of the original entry but append the correction.

3. RIGHT TO OBTAIN ACCOUNTING OF DISCLOSURES.

In accordance with 45 C.F.R. §164.528, you have the right to obtain an "accounting" of disclosures of your PHI made within six years before the request, starting from the effective date of April 14, 2003.
The accounting shall include disclosures of your PHI made by both our office and our business associates and shall include the date, receipt name and address, description of the information disclosed, and the purpose of the disclosure.

Our office is required to respond within 60 days following a receipt of a written request from you. Disclosures exempt from the accounting requirement include those: (a) to carry out treatment, payment or health care operations; (b) to you or your personal representatives; (c) for incidental purposes such as the office sign-in sheet; (d) to family members and others involved in your care; (e) for national security or intelligence purposes; and (f) correctional institutions and other law enforcement agencies under the custodial exception.

4. RIGHT TO REQUEST RESTRICTION OF USE OR DISCLOSURE.

In accordance with 45 C.F.R. §164.522(a), you have the right to request restrictions on how our office will use or disclose your PHI for treatment, payment, or health care operations and how your information will be disclosed to family members

or others involved in your care. Our office is not required to agree to such restriction. However, if we agree, then we are obligated to comply with that agreement unless the information is required for an emergency, or is requested for law enforcement, judicial and administrative proceedings or research.

5. RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATION.

In accordance with §164.522 (b), we will accommodate reasonable request from you to receive communications of your PHI by alternative means or at alternative locations. For example, you may request our office not to send certain medical information to your home, so that a family member cannot access that information.

6. RIGHT TO RECEIVE NOTICE OF PRIVACTY PRACTICES.

In accordance with 45 C.F.R. §164.520, you have the right to receive a notice of our office's privacy practices that describe the uses and disclosures of PHI, your rights under the Privacy Standards and our legal duties regarding PHI. We are required to inform you of your right to complain to our office or the Department of Health and Human Services (DHSS) Secretary, if you believe that your privacy rights have been violated. If you have any questions or if you wish to register a complaint, contact the administrator for your provider.

Privacy Officer
8750 Wilshire Blvd. Suite 350
Beverly Hills, CA 90211
Phone: 310-652-0010

The notice referred to in the preceding paragraph will be in plain language. Our office reserves the right to change its privacy practice in its privacy notice, but we will first publish a revised notice prior to any change in practices. Our office will provide its notice to patients upon request, at first service and on our Web Site if a web site is available.

7. RIGHT TO CONSENT TO OR AUTHORIZE CERTAIN USES AND DISCLOSURES.

As discussed in the section on uses and disclosures of PHI, infra, certain uses or disclosures will require your permission, whether consent, authorization or advance notice with an opportunity to object. In each of these circumstances, you have the right to grant or withhold that permission.

8. RIGHT TO COMPLAIN OF PRIVACY VIOLATIONS.

You have the right to complain if your privacy rights have been violated. You may complain to the contact person/privacy officer at this office, whose name, phone number and address are listed below. You may also complain to the DHSS Secretary through the Office of Civil Rights at 1-866-627-7748.

We cannot require that you waive this right as a condition for providing treatment, payment or other services and cannot retaliate against you for lodging a complaint with the Secretary.

ATTUNE HEALTH

NOTICE OF PRIVACY PRACTICES
8750 Wilshire Blvd., Suite 350, Beverly Hills, CA 90211

IN ACCORDANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA), 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.

If you have any questions about this notice, please contact our Privacy Officer at 8750 Wilshire Blvd., Suite 350, Beverly Hills, CA 90211

A. Who Will Follow This Notice

This Notice describes the privacy practices relating to protected health information ("PHI") followed by the providers at the practice and all of the employees and staff. The doctors, the office employees and staff may share your medical information with each other for treatment, payment of health care operations purposes described in this Notice.

B. Understanding Your Health Record/Information

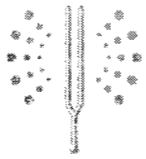
Each time you visit a physician, hospital or other healthcare provider, a record of your visit is typically made. This record generally contains your symptoms, examinations and test results, diagnosis, treatment and plan for future care or treatment. This information serves as a basis for planning your care and treatment; a means of communication among the doctors and other healthcare providers that are involved in your care; a medical-legal document describing the care you have received; a means by which you or a third-party can verify that services billed were actually provided; a source of data for medical research, education and data collection; a source of information for public health officials charged with improving community health and other healthcare operations.

C. Our Policy Regarding Medical Information

We understand that medical information about you and your health ("PHI") is personal. Our commitment to you is to protect medical information about you. Our office creates a record describing the care and services you receive at our office. This record is necessary in order to provide medical care to you and to comply with certain legal requirements. This notice applies to all of the records created in our office in connection with your care and treatment, whether made by the doctor and/or the employees and staff.

We may be sending automated SMS text/email reminders about your upcoming appointments. If this not authorized, please notify us. Please update us with your contact information, including your phone number regularly. We will only be sending you generic reminders, which include:

- Patient first name
- Appointment date and time
- Provider first and last name
- Location of the appointment



ATTUNE HEALTH

Autoimmune and Inflammation Care and Research

CONSENT TO RELEASE MEDICAL RECORDS

Please fill out only if we need to request records from other Doctors.

Patient name: _____ Home Number: _____

Date of birth: _____ Cell Number: _____

I hereby authorize and request that _____
Name of facility/individual

_____
Address **City/State/Zip** **Phone number and Fax**

Release information from my records to the following:

Name of the Facility/individual: _____

_____
Address City/State/Zip

_____
Fax number, if applicable

Please be specific regarding record and dates requested Information to be released:

Diagnosis and record of treatment _____
Specific date/dates requested

Laboratory and/or X-ray reports _____
Specific date/dates requested

Entire file (excluding confidential and psychiatric records, if any)

Other_____

Be advised that if you are requesting a copy of your medical record, a copying fee shall apply.

It is prohibited by law to release/disclose the attached/enclosed information to anyone except those specified above. I understand that this Authorization alone may not authorize release psychiatric or HIV information.

In signing, I am aware that this Authorization is valid for 30 calendar days after today

_____ _____
Patient Signature Date

DISPOSITION/DATE: Mailed certified/return receipt requested (date) _____
Faxed (date and time) _____ ID verification by_____

Records given to patient / date and time_____ Provider's approval_____

Patient will pick up ☐ Patient Paid: Date:_____