FOOTHILL CENTER FOR PAIN MANAGEMENT
HILARY J. FAUSETT, M.D.

1505 WILSON TERRACE, SUITE 240
GLENDALE, CALIFORNIA 91206

PATIENT INFORMATION

PATIENT NAME:	LAST:		FIRST:		MIDDLE INTIAL:
GENDER: (CHECK ONE)	○ MALE	○ FEMALE	BIRTHDATE:	AGE:	TODAY'S DATE:
STREET ADDRESS:			SOCIAL SECURITY #:		DRIVER'S LICENSE #:
P.O BOX:	CITY:			STATE:	ZIP CODE:
TELEPHONE NUMBERS:	HOME:	CELL:		WORK:	
MARITAL STATUS: (CHECK ONE)	○ SINGLE	○ MARRIED	○ SEPARATED	○ DIVORCED	○ WIDOWED
OCCUPATION:			EMPLOYER:		
EMAIL ADDRESS:					
REFERRING PHYSICIAN:			TELEPHONE NUMBER:		
PRIMARY CARE:			TELEPHONE NUMBER:		

INSURANCE INFORMATION

PRIMARY INSURANCE:	POLICY NUMBER:	GROUP NO.:	CO-PAY:
SUBSCRIBER'S NAME:	DATE OF BIRTH:	TELEPHONE:	
RELATIONSHIP (CHECK ONE)	○ SELF ○ SPOUSE	○ CHILD	○ OTHER
SECONDARY INSURANCE:	SUBSCRIBER'S NAME:	GROUP NO.:	POLICY NUMBER:
RELATIONSHIP (CHECK ONE)	○ SELF ○ SPOUSE	○ CHILD	○ OTHER

IN CASE OF EMERGENCY

NAME OF CONTACT:	RELATIONSHIP TO PATIENT:	TELEPHONE NUMBER:

OFFICE PAYMENT POLICY

We are committed to providing you with the best possible care. Your clear understanding of our payment policy is important to our professional relationship. We, therefore encourage you to speak with us regarding any questions you might have about our fees and your financial obligations.

It is important that you understand that you health insurance and/or you managed care plan are a contract between you and the insurance carrier. We are not a party to this contract. We provide services to you the patient, not to the insurance company. The insurance company is responsible to you, the patient, and you are responsible to the doctor.

If your insurance carrier does not pay the account within three months after we have rendered service, you will be responsible for the payment in full. If you have not met your deductible, YOU, THE PATIENT, ARE RESPONSIBLE FOR THE DEDUCTIBLE PAYMENT AMOUNT.

Please inform our staff of the type of insurance you have. ALWAYS bring your insurance card with you for your scheduled visit. If your insurance policy is in your spouse's name, please inform us.

If you are a PPO participant, it is YOUR responsibility to bring in the authorization or referral form. YOU ARE RESPONSIBLE FOR THE CO-PAYMENT AMOUNT.

If you have MEDICARE, you are responsible for the deductible as well as the co-payment. If you have a senior care supplement coverage plan, we will file the claim with you insurance carrier.

We accept cash, personal checks, Visa, and MasterCard.

THIS RELEASE AUTHORIZES HILARY J. FAUSETT, M.D. TO RELEASE ANY INFORMATION REQUEST TO MY INSURANCE CARRIER.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO HILARY J. FAUSETT, M.D. FOR THE MEDICAL BENEFITS FOR SERVICES PROVIDED

I HEREBY AUTHORIZE PHOTOCOPIES OF THIS FORM TO BE VALID AS THE ORIGINAL

Insured/Authorized Person's Signature _____

Date: _____

REQUEST FOR RESTRICTION ON THE MANNER/METHOD OF CONFIDENTIAL COMMUNICATIONS

You may request to receive confidential communications of PHI by alternative means or at alternative addresses. For example, you may not want your appointment notices or your bill to go to your home where a family member might see it.

We may not ask you the reason for your request. We will accommodate all reasonable requests.

If you make a special request, you must give us an alternative address or other method of contacting you (phone number, email address, etc/). Please specify how or where you wish to be contacted:

_____

_____

_____

_____

_____

Name:_____

Date:_____

Signature of patient or representative:_____

If representative, give relationship: _____

For more information about your privacy rights, see the "Notice of Privacy Practices".

If you believe your privacy rights have been violated, you may file a complaint with the hospital or with the Secretary of the Department of Health and Human Services. To file a complaint with the hospital, contact Christine Rangel (818) 241-4500.

Summary of the HIPPA Privacy Policy

- **The Privacy Rule is intended to:**
  - **Protect and enhance rights of consumers by providing them**
    - **Access to their health information**
    - **Control over PHI uses and disclosures**
  - **Improve healthcare quality by restoring public trust and willingness to share information**
  - **Improve efficiency and effectiveness by creating uniform nationwide privacy framework**
- **Covers electronic, paper and oral information**
- **Requires contracts with business associates to protect health information**
- **Emphasizes "minimum necessary" access**
- **Standards apply to "protected health information": all individually identifiable health information in any form**
  - **General Rule: Protected health information may not be used or disclosed for reasons other than treatment, payment or healthcare operations without specific patient authorization**
- **Patients must receive written notice of provider's information practices; practice must make good faith effort to obtain acknowledgement of receipt.**
- **Patient may inspect their own health information or obtain a copy**
- **Patients may request amendment to health information**
- **Patient may receive an accounting of disclosures for purposes other than treatment, payment and healthcare operations.**
- **Patients may request that uses and disclosures of health information be restricted.**
- **Patients must be provided means to report a privacy complaint.**
- **Providers can release PHI without authorization for treatment, payment or healthcare operations, or:**
  - **When required by law**
  - **Public Health Activities**
  - **For victims of abuse, neglect or domestic violence**
  - **Health oversight**
  - **Judicial proceedings**
  - **Specific law enforcement activities**
- **Providers must obtain a written patient authorization before releasing PHI for purposes other than Treatment, Payment, and Health Care Operations, such as:**
  - **Marketing**
  - **Medical research**
  - **Fund-Raising.**
- **Authorizations generally address a specific need and circumstances or span of time**
- **Authorizations are required before psychotherapy notes can be released**
- **Providers must identify all Business Associates that have access to or use/disclose protected health information of patients**
  - **Business Associate contracts must be established to ensure that Business Associates practices support HIPPA's requirements; sanctions must be applied for non-compliance by Business Associates**
- **Providers may release patient's location, condition, or death when needed to family, friends, others involved in the care of the patient**
- **Providers may make other disclosures to family and others involved when in the patient's best interest**

Name:_____ **Signature:**_____

Date:_____

Foothill Center For Pain Management

Hilary J. Fausett, M.D.

1505 Wilson Terrace, Suite 240
Glendale, California 91206
(818)241-4500

Dear Patient;

Foothill Center for Pain Management strives to render excellent medical care to you and all of our patients. In order to be consistent with this philosophy, we use an appointment system that sets aside time for a patient dependent on that patient's current needs. When you do not show for your appointment or notify us of your inability to keep your appointment by phone at least 24 hours in advance, the time that has been allotted for your visit cannot be used to treat another patient and its time lost to our office. With that in mind and in order to keep costs as low as possible, a Medical Appointment Cancellation Policy has been put into place:

Our policy is as follows:

We request that you please give our office a 24 hour notice in the event that you need to reschedule your appointment. This will also make it possible to reschedule your appointment more efficiently. If a patient misses an appointment and does not contact us with at least a 24 hour notice, we consider this to be a missed appointment. ("No Show, "No Call") and the following fees will be accessed:

Follow Up/Office Visit: $25.00

No show: $25.00

Same day Rescheduling Fee: $25.00

New Patient Consult: $50.00

As a courtesy we do make reminder calls for appointments. If you do not receive your message or we have incorrect information the cancellation policy will still be in effect.
If you are late for an appointment (Not to exceed 15 minutes), you will be seen as soon as possible, though the office visit may need to be shortened in length. Please be aware that patients who are significantly late three or more times will be viewed as a voluntarily withdrawn from the practice
If you have any questions regarding this policy, please let out staff know and we will be glad to clarify any questions you may have.
We thank you for your patronage.

I have read and understand the Medical Appointment Cancellation Policy and reminder of our Tardiness Policy of the practice and agree to be bound by its terms. I also understand that this notice may be changes at any time by the practice.

_____ _____

Signature of the Patient or Responsible Party **Date**

_____ _____

Printed Name of the Patient **Witness**