Premier ENT
EAR NOSE THROAT

Welcome to Premier ENT, thank you for choosing our practice for your Ear, Nose and Throat health care needs. Our goal is to meet your individual needs and to provide quality medical care in a convenient, comfortable setting.

Our office is open five days a week, Monday through Friday 8:30am until 5:00pm. Should you need to contact us during regular hours, just dial (909)793-2500 and follow the prompts to speak with a member of our staff.

Enclosed you will find a number of papers for you to read, complete, and sign. We ask that you bring these papers with you to your scheduled appointment.

- Patient Registration
- Medical History Form
- Notice of Privacy Policies and your Rights as a Patient

Please bring with you to the appointment:

- **Your insurance card(s)**
- **Your copay**
- **A photo ID**
- **All of the papers in this packet**
- **A current medication list**
- **Results from recent lab work or radiology studies (x-ray, CT scan, ultrasound, etc.)**

We understand that you have many choices when it comes to finding a healthcare provider, and we are pleased you have chosen Premier ENT. We look forward to meeting you and providing you with high quality medical care.

You can find out more about us by visiting our website: **www.premierentmed.com**

Thank You,
Premier ENT Administration

ATTENTION – Regarding Insurance

ARE YOU COVERED?

Premier ENT is contracted with the following insurance carriers. **Due to constant changes in the insurance industry, you should always verify with your insurance that it is in network with our providers by calling the customer service number on the back of your insurance card.**

ALL MAJOR CARRIERS

- Aetna/US Healthcare
- Blue Cross
- Healthnet
- Humana
- Medicare
- PHCS

HMO

- Aetna/US Healthcare
- Blue Cross
- Blue Shield
- CIGNA
- Healthnet
- Humana
- Medicare
- PHCS
- Scan
- United Healthcare

GROUP AFFILIATES

- Inland Health Org.
- Physicians Health Network
- Pinnacle
- Prime Care
- Kaiser
- RYMG
- Regal
- SBMG
- United Family Health Care

_____

I understand if I have an unpaid balance to Premier ENT and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of the fee of any collection agency, which may be based on a percentage at a maximum of 35% of the debt, and all costs and expenses, including reasonable collection and attorney's fees incurred during collection efforts.

In order for Premier ENT or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Premier ENT and the designated external collection agency are authorized to (i) contact me by telephone at the numbers I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing service, as applicable. Furthermore, I consent to the designated external collection agency to share personal contact and account related information with third party vendors to communicate account related information via telephone, text, email, and mail notification.

Thank You,
Premier ENT Administration

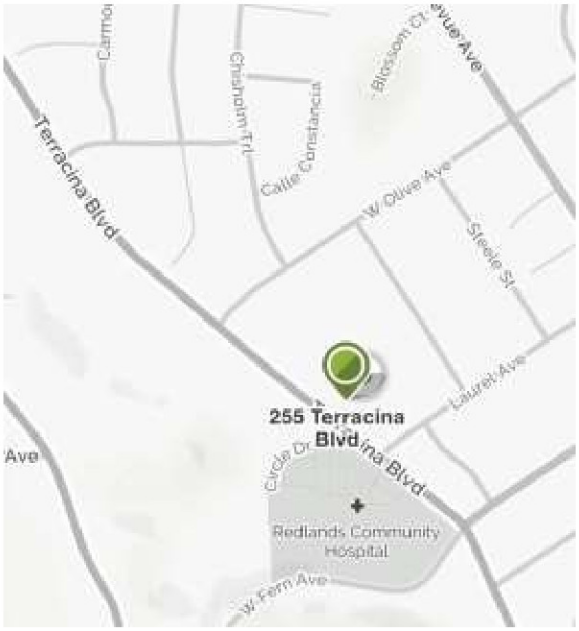
DIRECTIONS

PREMIER ENT, A MEDICAL CORPORATION

255 Terracina Blvd.
Suite 201A
Redlands, CA 92373

CALL US:

909-793-2500



From Banning, Beaumont, Yucaipa, Calimesa:
Interstate 10 West towards Los Angeles, Exit Cypress Avenue (under freeway), and Continue until Cypress becomes Terracina. Turn right into parking lot, across from Redlands Community Hospital

From Loma Linda, San Bernardino, Colton, Fontana:
Interstate 10 East towards Palm Springs, Exit Alabama Street. Turn right at Barton Road (signal), Turn left onto Terracina Boulevard (signal), Turn Left into parking lot, across from Redlands Community Hospital

Thank You,
Premier ENT Administration

Premier ENT, A Medical Corp.
Johnny Arruda, M.D., F.A.C.S
255 Terracina Boulevard, Suite 201A, Redlands, CA 92373
Tel: (909) 793-2500
www.premierentmed.com

Patient Information

Date:	☐New ☐Change			Doctor:
Patient's Name (Last, First, MI):				
Address:				
City:	State:	Zip:	E-mail:	
Home Telephone #:	Cell/Other Telephone #:		Work Telephone #:	
Employer:				
☐Male ☐Female	Marital Status:	Date of Birth:	Age:	Social Security #:
Emergency Contact:		Telephone #:		
Insurance:		ID #:		

RESPONSIBLE PARTY FOR BILLING: (IF DIFFERENT THAN ABOVE)

Name (Last, First, MI):			
Address:	City:	State:	Zip:
Patients Relationship To Responsible Party: ☐ Self ☐ Spouse ☐ Child ☐ Other			

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

Please Initial:

_____ In order to control your cost of billings, we request that our charges for office visits be paid at the conclusion of each visit.

_____ If this account is assigned to an attorney for collection and/ or suit, the prevailing party shall be entitled to reasonable attorney's fee and cost of collection.

_____ To the extent necessary to determine liability for payment and to obtain reimbursement, I authorized disclosure of portions of the patient's record.

I hereby assign all medical and/ or surgical benefits to include major medical benefits to which I am entitled including Medicare's, private insurance, and other health plans to: Premier ENT, A Medical Corp., Johnny Arruda, M.D., Inc.
This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as a valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorized said assignee to release all information necessary to secure the payment. I hereby authorize evaluation and treatment by Johnny Arruda, M.D., F.A.C.S.

Signed:	Date:

Premier ENT, A Medical Corp.

Johnny Arruda, M.D., F.A.C.S

255 Terracina Boulevard, Suite 201A, Redlands, CA 92373
Tel: (909) 793-2500
www.premierentmed.com

Financially Responsible Party Information

Full name: _____
First Middle Last

Social security number: _____

Driver's license number: _____

Date of birth: _____

Telephone Number: _____

Please provide all the information requested above. The undersigned responsible party agrees that they are responsible for all fees incurred, regardless of insurance coverage. All copayments and deductibles are due at the time of service. If payment has not been received from the insurance company within 60 days from the date of service, the patient or the financially responsible party accepts responsibility for payment in full.

Signature: _____ Date: _____

Patient Medical History and Review of Systems

Patient Name: _____ Date of Birth: _____ Todays date: _____

Referring Doctor: _____ Height: _____ Weight: _____

Occupation: _____ Retired from: _____ Race: _____ Ethnicity: _____

Reason for todays visit: _____

Previous medical issues or injuries: _____

Family history of any medical issues: _____

Have you ever smoked? _____ Packs per day: _____ How many years? _____ Any alcohol? _____ How much? _____

Any other drugs? _____ Vaping? _____ # per day _____ Any caffeine? _____ How much? _____

Do you have any allergies to medications? _____ If so, what medications? _____

Are you allergic to contrast? _____ If so, what type? _____

What surgeries have you had? _____

Medication list (dosage): _____

_____What pharmacy do you use? _____

Social history: Married: _____ Divorced: _____Longterm relationship: _____ Single: _____

Have you ever experienced problems with the following? Please check

Constitutional ☐ Weight gain ☐ Weight loss ☐ Night sweats ☐ Insomnia	**Neurological** ☐ Numbness ☐ Weakness ☐ Headaches ☐ Stroke	**Musculoskeletal** ☐ Arthritis
Ear, Nose, Throat ☐ Hearing loss ☐ Ringing noise ☐ Nasal congestion ☐ Sinus problems ☐ Trouble swallowing ☐ Hoarseness	**Respiratory** ☐ Trouble breathing ☐ Snoring ☐ Asthma ☐ TB ☐ Pneumonia or bronchitis	**Eyes** ☐ Double vision ☐ Vision loss ☐ Glasses
Allergic / Immunologic ☐ Sneezing ☐ Itchy eyes/nose/throat ☐ Allergy shots ☐ Skin rash ☐ HIV	**Gastrointestinal** ☐ Indigestion / heartburn ☐ Ulcers ☐ Hepatitis ☐ Bloody or black stool	**Endocrine** ☐ Diabetes ☐ Thyroid disease ☐ Pituitary disease
Cardiovascular ☐ High cholesterol ☐ Heart disease ☐ Rheumatic fever ☐ Heart murmur ☐ High blood pressure	**Genitourinary** ☐ Bladder control ☐ Prostate disease ☐ Kidney disease	**Hematologic** ☐ Bleeding disorder ☐ Anemia
Psychiatric ☐ Depression ☐ Other		

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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 of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in 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 relate 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 both 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 them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in 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: Procedure and Applicable Law: A demand for arbitration must be communicated 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 rate 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 fee's 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 absolute right to arbitrate the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and join 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 join existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions in California Law applicable to health care providers shall apply to disputes within this arbitration agreement. Including but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code or 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 one 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 California Code of Civil Procedure provisions relating to arbitration shall govern the arbitrators.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days of 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 signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of the first medical services _____

Patient's or Patient Representative's INITIALS

If any provision of this arbitration agreement is held invalid or 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 this contract.

Patient Name (Print)	Signature	Date
	Witness Signature	Date

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Privacy Agreement (HIPAA)

PLEASE READ IT CAREFULLY

The Health Insurance Portability Act of 1996 ("HIPPA") is a federal program that requires all medical records and other individually identifiable health information used or disclosed by use in any form, whether electronically, on paper, or verbally, are kept properly confidential. This Act gives you the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for entities that misuse health information.

As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may disclose your medical records for each of the following:

- • Treatment: Providing, coordinating or managing healthcare related services for one or more healthcare providers, such as a physical exam.
- • Payment: Activities such as obtaining reimbursement for services, confirming coverage, billing or collecting procedures and utilization review.
- • Healthcare Operations: Include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service.

We may also create and distribute de-identified health information by removing all references to individually identifying information.

We may contact you to provide appointment reminders or treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures may be made only with your written authorization. You may revoke such authorization in writing and we are required to honor that request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosure of protected health information, including those related to disclosure to family members, friends, or any other person identified by you. We must abide by such restrictions, unless you remove the restriction in writing. However, we are not required to agree to the restriction.
- The right to reasonable requests to receive confidential communication of protection of health information from us by alternative means or at alternative locations.
- The right to inspect or copy your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice upon request.

I understand that as part of my healthcare, this organization originates and maintains healthcare records describing my health history, symptoms, examinations, test results, diagnoses, treatment, and any plans or care regarding 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 that 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, such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a "Notice of Privacy Practices", which provides a more complete description of the information uses and disclosures. I understand that I have the right to review the notice prior to signing this acknowledgement. I understand that the organization reserves the right to change their notice and practices and that prior to implementation, will mail a copy of the revised notice to me at the address I have previously provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or other health-related operations and that the organization is not required to agree to the restrictions requested. I acknowledge receipt of this organization's "Notice of Privacy Practices". (Notice effective date or versions: August 30, 2007)

Patient Name (Print)	Signature	Date

NOTICE AND ACKNOWLEDGMENT OF RECEIPT AND UNDERSTANDING NOTICE TO PATIENTS

Medical doctors are licensed and regulated by the Medical Board of California.

To check up on a license or to file a complaint go to

www.mbc.ca.gov,
email: licensecheck@mbc.ca.gov,
or call (800) 633-2322.

_____	_____
Date	Patient's Name (Type or Print)
	_____
	Patient's Signature
_____	_____
Date	Patient Representative's Name and Relationship (Type or Print)
	_____
	Patient's Representative's Signature

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California Assembly Bill 1278

Pursuant to Assembly Bill (AB) 1278, physicians are required to provide notice to patients regarding the Open Payments Database, managed by the US Centers for Medicare and Medicaid Services (CMS). This database is a federal tool used to search payments made by drug and device companies to physicians.

It can be found at https://openpaymentsdata.cms.data

Name	Signature	Date

PLEASE COMPLETE BACK PAGE

CANCELLATION AND NO-SHOW APPOINTMENT POLICY

We at Premier ENT understand that sometimes you need to cancel or reschedule your appointment and there are emergencies. If you are unable to keep your appointment, please notify us as soon as possible. Our goal is to provide quality care in a timely manner. In order to do so we have had to implement an appointment/cancellation policy. The policy enables us to better utilize available appointments for our patients in need of an appointment time.

Cancellation of an Appointment ~ In order to be respectful of the appointment needs of Premier ENT, please be courteous and call the office promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. This is how we can best serve the needs of our patients.

If it is necessary to cancel your scheduled appointment we require that you call by 10 a.m. one (1) working day in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to your appointment time.

How to Cancel Your Appointment ~ To cancel appointments please call (909) 793-2500. If you do not reach the receptionist you may leave a detailed message on the voice mail.

Late Cancellations

Late cancellations will be considered as a "no show".

No Show Policy ~A "no show" is someone who misses an appointment without canceling it by 10 a.m. one (1) working day in advance. No-shows inconvenience those individuals who need access to an appointment in a timely manner.

A failure to present at the time of a scheduled appointment will be recorded in the patients' chart as a "no show". An administrative fee of $25.00 for the first "no show" and $30.00 for subsequent "no shows" will be billed to the patients account or sent to the patient's home. The patient will be sent a letter alerting them to the fact that they have failed to show up for an appointment and did not cancel their appointment by 10 a.m. one (1) working day in advance. A copy of the letter will be placed in the patient file.

Thank you for you Cooperation, We appreciate your business!

I understand Premier ENT appointment cancellation and no-show policy and understand my responsibility to plan appointments accordingly and notify the receptionist appropriately if I have difficulty fulfilling my scheduled appointments.

_____

Patients Name (Print name)

_____ _____

Signature Date