Dr.Ving Yam, D.O. and Dr.Stephanie K. Iem, D.O.
701 E.Grand Ave.Suite 100
Escondido, CA 92069
760-294-8898

OFFICE POLICIES/PROCEDURES & FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Dr.Ving Yam, D.O. and Dr.Stephanie K. Iem, D.O. We are committed to delivering excellent primary care. Please review our office and financial policies and procedures. We will be happy to answer any questions you may have.

APPOINTMENTS:

I understand that appointments are pre-arranged and that it is my responsibility to keep my appointment or **cancel my appointment with a minimum of 24 hours notice.** If my appointment is missed or canceled with short notice, it deprives another patient the opportunity to be seen during that time. Missed appointments or failure to cancel an appointment with more than 24 hours notice will result in a $25 charge to my account.

BILLING/INSURANCE:

I understand and agree that it is my responsibility to know my insurance coverage, including deductibles, co-payments, co-insurances and prescription coverage, and how it applies to medical treatment in this office. Presenting my insurance card to this office does not guarantee payment by my insurance company. Regardless of my insurance status, I am ultimately responsible for the balance of my account for any medical services rendered. I understand that payment is due at the time of service. I can pay via cash, check, MasterCard or Visa. Although the office bills contracted insurance companies, deductibles, co-payments and co-insurances are due and payable at each visit. I understand that I am responsible for services not covered by my insurance company. Additionally, cosmetic products and certain cosmetic services must be paid for before the end of the visit by either cash or credit card. No checks will be accepted for these. There will be a $25 service fee for every check returned by the bank for non-sufficient funds, stop payments, etc. Statements or bills are due upon receipt, and a service fee of $10 will be added to any unpaid balance after 30 days past due. If it becomes necessary to refer my account to a collection agency, I will be responsible for all charges assessed by the collection agency in addition to the outstanding account balance.

RECORDS:

Records will be kept for seven years as per legal requirements. Copies of medical records can be transferred to other physicians upon receipt of written notification from the patient. **Please provide the office with at least five business days notice when requesting records.** I understand that there will be a minimum $25 fee for any medical records released for personal use. The fee may be higher depending on the amount of work involved in transferring the records.

MISCELLANEOUS PATIENT REQUESTS:

I understand that there will be a fee for miscellaneous personal requests such as filling out forms, letters, financial reports, etc. Please ask our office for the fee should you have a personal request.

MEDICATIONS:

Medication refills will be considered during office hours only. NO refill requests will be handled after hours or on weekends. This is to conform to the California Pharmacy statutes and to allow for the maintenance of accurate records of medication consumption in the patient's chart for review by the State Pharmacy Review Board if necessary. **Patients should contact their pharmacy 1-2 days prior to the needed refill** as the physician may not be immediately available the same day the medication runs out. **Your provider will need 3 business days advanced notice to pick up your WRITTEN prescription.** Certain medications will not be refilled without a physical examination, and others will not be refilled after **3 months from the last date of service**, i.e narcotics. **No refills will be provided to any patient that has not been seen in this office in the last 6 months.**

I understand and agree to all of the above office and financial policies and procedures and still want to receive professional medical services form Dr. Ving Yam, D.O. and Dr. Stephanie K lem, D.O. All of my questions have been answered to my satisfaction.

_____ _____

Print Patient's Name Date

_____ _____

Signature of Patient or Guardian Print Guardian's Name

Welcome To Our Office! **Dr.Ving Yam.D.O. and Dr.Stephanie Iem. D.O.**

Name:_____ Today's Date:_____
First Middle Last
Birthdate:_____ Age:_____ SSN:_____ Sex:_____

Home Address:_____
City:_____ State:_____ Zip:_____ Telephone:_____
Email Address:_____ May we contact you via e-mail? ○ YES ○ NO
Occupation:_____ May we contact you at work? ○ YES ○ NO

Employer:_____ Years There:_____

Spouse:_____ Birthdate:_____ Age:_____ SSN:_____

Occupation:_____ Employer:_____ Years There:_____

Employer's Address:_____ City:_____ State:_____

Zip:_____ Employer's Telephone:_____ Spouse Cell:_____

In case of emergency, contact:_____ Relationship:_____
(Someone not living with you)
Home Phone:_____ Work Phone:_____ Cell:_____

How did you learn about our practice? Referring Doctor:_____
My friend,_____ recommend you. □Yellow Pages □Hospital call center □
Internet □My managed care plan book Other:_____

INSURANCE CARRIER:_____ ID#_____

POLICY HOLDER NAME:_____ RELATIONSHIP TO PATIENT:_____

Birthdate:_____ SSN:_____ Telephone:_____

Name of Secondary Insurance Company:_____ ID#_____

PLEASE FURNISH YOUR INSURANCE CARDS AND A PICTURE I.D. UPON REQUEST.

THE PATIENT IS RESPONSIBLE FOR ALL PROFESSIONAL SERVICE FEES REGARDLESS OF INSURANCE COVERAGE. Co-payments must be paid when services are rendered unless arrangements have been made in advance. Appropriate insurance forms will be submitted for all Insurance Carriers.

AUTHORIZATION TO PAY BENEFITS TO PHYSCIAN

I hereby authorize payment directly to Dr.Ving Yam and Dr. Stephanie Iem of any medical benefits otherwise payable to me for services rendered. I understand and agree that I am financially responsible to said physician for any changes not covered by this assignment.

SIGNATURE:_____ DATE:_____

Dr.Ving Yam,DO. and Dr.Stephanie Iem, D.O.

HISTORY AND PHYSICAL

Name: _____ Date: _____ Referring M.D. _____
Other M.D.'s : _____

REASON FOR VISIT:

DRUGS AND MEDICATION

List all medications you take, including dosage and how often:

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

SURGERIES, HOSPITALIZATIONS AND SERIOUS ILLNESSES

List all previous operations, hospitalizations and serious illnesses with reason and approximate dates:

1.
2.
3.
4.
5.
6.

Do you have any allergies.....□ No □ Yes
If so, to what and type of reaction? _____
Any anesthesia complication...□ No □Yes
What type? _____
Any bleeding problems?.....□ No □ Yes
What type? _____
Have you ever had a blood transfusion? □ No □ Yes

MEDICAL HISTORY AND PROBLEMS

Anemia ..... □ No □ Yes
What type? _____
Angina .....□ No □ Yes
Arthritis..... □ No □ Yes
Asthma.....□ No □ Yes
Bladder or kidney infection .....□ No □ Yes
Cancer.....□ No □ Yes
What type? _____
Congestive heart failure .....□ No □ Yes
Diabetes .....□ No □ Yes
What type? _____
Dialysis .....□ No □ Yes
When? _____
Where? _____
Diverticulitis.....□ No □ Yes
Emphysema.....□ No □ Yes
Gallbladder disease .....□ No □ Yes
What type? _____
Gastroesophageal reflux disease.....□ No □ Yes
Heart Attack.....□ No □ Yes
When? _____

High Cholesterol .....□ No □ Yes
Irregular heart beat .....□ No □ Yes
What type? _____
Kidney failure.....□ No □ Yes
Kidney Stones .....□ No □ Yes
Liver disease .....□ No □ Yes
What type? _____
Phlebitis or blood clots.....□ No □ Yes
What body part? _____
Pneumonia or lung infection.....□ No □ Yes
Prostate enlarged .....□ No □ Yes
Seizures..... □ No □ Yes
Stroke.....□ No □ Yes
When? _____
Thyroid disease .....□ No □ Yes
What type? _____
Ulcers.....□ No □ Yes
What type? _____
Varicose veins .....□ No □ Yes
High blood pressure.....□ No □ Yes
Any other problems?..... □ No □ Yes

DO YOU KNOW OR HAVE YOU EVER HAD..... **NOTES/EXPLANATIONS**

EARS,EYE,NOSE,THROAT:
Any eye disease, injury, impaired sight?..... □ No □ Yes
Any ear disease, injury, impaired hearing?.. □ No □ Yes
Any trouble with nose, sinuses, mouth and/or
Throat?.....□ No □ Yes

CARDIO-REPIRATORY:
Chronic or frequent cough? □ No □ Yes
Chest pain, pressure, or discomfort?..... □ No □ Yes
Shortness of breath?..... □ No □ Yes
Palpitation or irregular heartbeat?..... □ No □ Yes

GASTROINTESTINAL:
Trouble swallowing?..... □ No □ Yes
Nausea or vomiting?..... □ No □ Yes
Black or bloody stools?..... □ No □ Yes
Constipation or diarrhea?.....□ No □ Yes
Rectal pain, swelling or bleeding?..... □ No □ Yes
Has there been a change in .....
Your appetite or eating habits?..... □ No □ Yes
Your bowel habits or stools?..... □ No □ Yes
Abdominal pain or swelling?..... □ No □ Yes
Weight loss?..... □ No □ Yes
Weight gain?..... □ No □ Yes

GENITO-URINARY:
Urinary frequency or burning? .....□ No □ Yes
Do you get up at night to urinate?.....□ No □ Yes
How many times?_____
Any difficulty urinating?.....□ No □ Yes

EXTREMITIES:
Pain in leg or calf when walking?..... □ No □ Yes
Bone or joint swelling?..... □ No □ Yes
Swelling (feet or legs)? ..... □ No □ Yes
Pain in legs at night? .....□ No □ Yes
Numbness (arms or legs)? .....□ No □ Yes
Weakness (legs or arms)? .....□ No □ Yes
Burning (feet or legs)? .....□ No □ Yes
Coldness(hands or feet)? .....□ No □ Yes

NEUROLOGICAL:
Temporary loss or vision?..... □ No □ Yes
Temporary numbness or weakness of face,
arm, or leg?.....□ No □ Yes
Trouble with speech?.....□ No □ Yes
Fainting or loss of consciousness?.....□ No □ Yes
Any recent development of headaches?..... □ No □ Yes
Dizziness or vertigo?..... □ No □ Yes

FAMILY HISTORY:
Has any blood relative ever had: WHO
Cancer?..... □ No □ Yes _____
Diabetes?..... □ No □ Yes _____
Bleeding disorder?... □ No □ Yes _____
Vascular problems?. □ No □ Yes _____
Heart disease?..... □ No □ Yes _____
Lung problems?..... □ No □ Yes _____

Do you use tobacco?..... □ No □ Yes
What type?_____
If yes, how much _____day How long?_____years

When quit?_____
Do you drink?..... □ No □ Yes
If yes –how much?_____ How often?_____

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PRIVACY RIGHTS NOTIFICATION ACKNOWLEDGEMENT

By signing this form, you are granting consent to Dr.Ving Yam, D.O. and Dr.Stephanie Iem, D.O. to use and disclose your protected health information for the purpose of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our Privacy Officer at (760) 294-8898.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your account.

I hereby acknowledge receipt of the Notice of Privacy Practices.

Signature_____Date_____

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Office Policy:

1. Our office will make every effort to bill your insurance company for you, as long as we are contracted provider. In the event we are not with your insurance, you will responsible for billing your insurance company yourself.

2. In order for our office to bill Medicare Secondary Insurance Companies, we must have a copy of your secondary insurance card on file.

3. If your insurance has not paid our office within 60 days, you will be responsible for the bill. You must make a payment while you settle with your insurance company.

4. Delinquent account over 120 days will be sent to our Collection Agency, or in some cases, taken to court.

5. Monthly payments may be made, provided you do so in good standing and have made prior arrangements with our office.

Signature_____ **Date**_____