# WELCOME

**Welcome to Newport Beach Medical Associates (NBMA). The physicians and staff here at NBMA look forward to establishing a healthy medical relationship with you.**

**OFFICE HOURS: 8:00am to 12:00pm and 2:00pm to 5:00pm, Fridays close at 4:30pm**

**DIRECTIONS: We are located in the Newport Lido Medical Building at 361 Hospital Road, Suite 322, across from Hoag Hospital. Cross streets are Hospital Road and Placentia Road.**

**PRIOR TO YOUR FIRST VISIT**
Please read, complete and bring the enclosed forms, along with your **insurance & identification cards**, with you for your first visit. If you do not bring the completed information, your appointment may be delayed while you fill the forms out. Plan to arrive 15 minutes before your scheduled appointment time. If available, please bring copies of any medical history and lab work.

**APPOINTMENTS/ CANCELLATIONS**
Please call **(949) 574-0777** or your physicians designated concierge telephone number at least 24 hours prior to your appointment time to cancel. We appreciate your courtesy in cooperating with our request.

**LABORATORY RESULTS**
You will receive a call from the assistant or the doctor with your results within 5-7 days. If you have not heard from us within 2 weeks, please call for your test results.

**PHARMACY REFILLS**
Please ask your pharmacy to contact us or you can contact us directly.
Allow 24 hours for your prescription to be filled.

**MESSAGES TO YOUR DOCTOR**
All calls will be answered by the end of the day unless your doctor is out of the office. Please let us know if you are calling with a physical problem that needs immediate attention.

**AFTER HOURS**
A Physician is on call after hours and weekends for **emergencies**. Your doctor can be reached by calling your physicians designated concierge telephone number.

**COPYING OF MEDICAL RECORDS**
There is a $35 charge for a copy of your medical record for personal use. Please send your signed request along with your check, payable to “Integrated Business Solutions.”

**Thank you for choosing Newport Beach Medical Associates; we look forward to serving you for your medical care.**

# Newport Beach Medical Associates - AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

**Authorization for Use/Disclosure of Information:** I voluntarily consent to and authorize the following health care provider: _____ to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

**Recipient:** I authorize my health care information to be released to the following recipient(s):

- ❑ David Brouwer, MD
- ❑ Martin Bae, MD
- ❑ Michael Yu, MD
- ❑ David J. Chun, MD
- ❑ Jennifer Knox, MD
- ❑ H. Leon Daneschvar, MD

Information to be disclosed: **I authorize the release of the following health information: (check the applicable box below)**

**From Date:** _____ **To:** _____

- ❑ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.[1]
- ❑ Only the following records or types of health information:

_____.

**Please send information promptly by mail or fax to: Newport Beach Medical Associates**

361 Hospital Road, Suite 322
Newport Beach, CA 92663
**Phone: 949 – 574 – 0777 / FAX: 949 – 999 – 8146**

DURATION: Authorization shall remain in effect for one year from the date of signature below.

| _____ | _____ | _____ |
|---|---|---|
| Print Name AND Date of Birth | Signature | Date |

If Individual is unable to sign this Authorization, please complete the information below:

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| Name of Guardian/ Representative | Legal Relationship | Date | Witness |

[1] NOTE: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by the Lanterman-Petris-Short Act.

**Dear Valued Patient:**

**In an effort to better serve you our office is now prescribing your medications electronically. Please assist us and take a moment to fill in the following pharmacy information:**

NAME: _____ Date of Birth: _____ Phone Number: _____

Local Pharmacy Name: _____ Phone Number: _____

Address: _____

Mail Order Pharmacy: _____ Phone Number: _____

Fax Number: _____

**RX insurance:** _____ **Phone number:** _____

**ID#:** _____

**ALLERGIES:** _____

## MEDICATION LIST

| | Medication Name | Dose | Times per day |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |
| 9.. | | | |
| 10. | | | |
| 11. | | | |
| 12. | | | |
| 13. | | | |
| 14. | | | |
| 15. | | | |

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**
**NEWPORT BEACH MEDICAL ASSOCIATES**
**361 Hospital Rd., Suite 322, Newport Beach, CA 92663**

**Effective Date: 1/1/2014**

**Communication of Personal Health Information:**

General office policy is that no information may be left with anyone but the patient. Many patients may find multiple methods of communication acceptable, even though total confidentiality cannot be guaranteed.
Below is a list of communication options. Please circle the methods that are acceptable means of communicating information regarding your health. **PLEASE UNDERSTAND THIS GRANTS US PERMISSION TO COMMUNICATE ANY AND ALL INFORMATION TO YOU IN THIS MANNER.**

**CIRCLE** desired communication for **leaving messages:** **HOME** **OFFICE** **CELL**

**Leave Messages** with Spouse/ Designated Family Member: **Yes** **No**

**Discuss Test Results or medical condition with spouse or relative:** **Yes** **No**

**NAME OF AUTHORIZED RELATIVE:** _____

**Health Information Exchange (HIE)** This practice is participating in the Hoag Health Information Exchange, an electronic system through which it and other participating healthcare providers can share patient information according to nationally recognized standards and in compliance with federal and state law, that protects your privacy. Through the HIE, your participating providers will be able to access information about you that is necessary for your treatment, unless you choose to have your information withheld from the HIE by personally opting out from participation.

If you chose to opt out of the HIE (that is, if you feel that your medical information should not be shared through the HIE), We will continue to use your medical information in accordance with this Notice of Privacy Practices and the law, but will not make it available to others through the HIE. To opt out of the HIE, please contact the Hoag Director of Health Information Exchange in writing at: One Hoag Drive, Newport Beach, CA 92663, or by telephone at 949 – 764 – 8722.

**EMERGENCY CONTACT INFORMATION:**

**Emergency Contact Name:** _____

**Relationship to Patient:** _____

**Emergency Contact Phone #:** _____

**Emergency Contact Alternate #:** _____

I hereby acknowledge that I received a copy of the Notice of Privacy Practices for Newport Beach Medical Associates. I further acknowledge that a copy of the current notice is posted in the reception area and that any amended Notice of Privacy Practices will be made available at my next appointment.

**Name of Patient:** _____ **Date of Birth:** _____

**SIGNATURE REQUIRED:** _____ **Date:** _____

**Guardian Name and Signature:** _____

**Relationship to Patient:** _____

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Dear Patients, to assist our practice meet Medicare / Government Regulations; we would appreciate your answer to the following questions:

Pt. Name:_____ Date of Birth:_____

**TOBACCO USE:**

Tobacco use: Current Former Never

Type: Cigarettes Cigar Pipe Chewing Tobacco

Packs / Units per Day: _____

Ever tried to quit: NO / YES Year Quit:_____

**Race:**
Asian
African American
Caucasian / White
Hispanic
Multiracial
Native American
Other Race

**Ethnicity:**
Hispanic / Latino
Not Hispanic or Latino

**Primary Language:** _____

☐ I decline to answer

**THANK YOU.**
Newport Beach Medical Associates

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**Dear Patient:**

**When one of our patients has any type of laboratory test, x-ray or pathology results pending, and has not heard from us, Newport Beach Medical Associates requests that the patient calls our office for these results.**

**If you have not heard from us within 2 weeks of taking your test, do not assume your results are normal.**

**We feel that you should know your results, and that you take responsibility to make sure you know they have been reviewed.**

**If abnormal test results are found, we plan to inform you. At times however, the results are sent to the wrong physician and not to our office. By participating in your care and assuring that you know the tests taken have been received and reviewed by the physician personally, we can act together as a team to achieve the highest quality health care.**

**I have been informed and understand that I am responsible for making sure my test results have been received/reviewed by my doctor.**

_____ _____

**Print Patient / Responsible Party** **Date**

_____ _____

**Signature** **Date**

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## GUARANTEE OF FINANCIAL RESPONSIBILITY FOR PROFESSIONAL SERVICES

I understand that any eligibility for benefit coverage of professional and other services by my health plan is not a guarantee of payment for services rendered to me.

I wish to receive medical services from Newport Beach Medical Associates at this time. In the event I am ineligible for benefits from a health plan I understand that I will be fully/personally responsible for all services and supplies provided to me. I will pay all such charges when I am presented with a bill.

In the event I have no health insurance coverage or I refuse to guarantee the financial responsibility, I understand I must pay for all services rendered at the time of service.

Patient Name: _____
(PLEASE PRINT)

_____ _____
SIGNATURE DATE