INDUSMEDICAL ASSOCIATES

# DEMOGRAPHICS

DATE / FECHA _____

PATIENT'S FULL NAME: _____ PHONE: _____
(NOMBRE COMPLETO) (NUMERO DE TELEFONO)

D.O.B: ____/___/_____ SEX / SEXO: M F SOCIAL SECURITY NUMBER: _____ - _____ - _____
(FECHA DE NACIMENTO) (NUMERO DE SEGURO SOCIAL)

ADDRESS: _____ CITY: _____
(DIRECCION) (CIUDAD)

STATE: _____ ZIP CODE: _____
(ESTADO) (ZONA POSTAL)

MAILING ADDRESS: _____ CITY: _____
(DIRECCION DE CORREO) (CIUDAD)

STATE: _____ ZIP CODE: _____
(ESTADO) (ZONA POSTAL)

NAME OF SPOUSE: _____ E-MAIL _____

(NOMBRE DE ESPOSO / ESPOSA)_____ CELL: _____

ETHNICITY: _____
(ORIGEN ETNICO)

PREFERRED LANGUAGE: _____
(LENGUAJE PREFERIDO)

RACE: _____
(RAZA)

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## EMERGENCY CONTACT / CONTACTO DE EMERGENCIA

NAME: _____ NAME: _____
(NOMBRE) (RELATIONSHIP TO PATIENT) (NOMBRE)

ADDRESS: _____ ADDRESS: _____
(DIRECCION) (DIRECCION)

PHONE # _____ PHONE # _____

NAME OF YOUR PHARMACY / NOMBRE DE SU FARMACIA : _____

CITY / CIUDAD: _____ PHONE / NUMERO DE TELEFONO: _____

760.202.0686
www.indusmedicalassociates.com
35400 Bob Hope Drive, Suite 209
Rancho Mirage, CA, 92270

INDUS MEDICAL ASSOCIATES

# Patient Financial Agreement

1. I understand that I am required to pay for all the charges on the date services are rendered, unless I am covered by a health plan in which my doctor is a participating physician, and I am being seen for a service I know to be covered by my policy.

2. I understand that Indus Medical Associates accepts personal check, cash or credit card. If the bank returns my check for insufficient funds, I will be charged a $25.00 service fee, which will be due and payable within three days along with the amount of the original check.

3. I understand that if I receive a statement in the mail, the amount is my responsibility and is due in 10 days.

4. If my account exceeds 90 days, I understand that I am in a collection status and a financial charge equal to 1% per month may be added to my account.

5. If unable to keep appointment, please let us know 24 hours in advance to avoid a $25.00 cancellation fee.

6. For any form to be filled out there is a charge of $20.00 per form.

## Medical Insurance Policies

1. I understand that I am ultimately responsible for my account in full, even though I have medical insurance, should there be a problem with my insurance company not paying in a timely manner or for the amount I feel is correct, I agree to pay the doctor and settle my differences with my insurance company.

2. I will pay all deductibles or percentages due on the day of service, or in the case of surgery, a partial payment will be required prior to hospitalization.

3. I hereby authorize disclosure of medical information to my stated initial insurance company for the purpose of obtaining payment for services rendered.

MEDICARE PATIENTS

4. I have been given and have read MEDICARE'S ABN form on annual physical exams and routine tests and I am aware that the services rendered **may not be covered** by MEDICARE; therefore, I will be solely responsible for payment.

| _____ | _____ | _____ |
|---|---|---|
| PRINTED NAME | SIGNATURE | DATE |

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# OFFICE POLICY ON PRESCRIPTIONS

Patients are expected to carefully safeguard all prescriptions from loss, misuse, and theft. It is also your responsibility to use them properly as directed by your doctor.

If you have any problem with your prescription, or are asking for an early refill for any reason, you must contact the office. In most cases you will be require to make an appointment and see the doctor for an early or a change of prescription.

If there is a theft of any schedule prescription drug, a police report should be filed, and a copy of the paperwork presented to this office. We may obtain a report from the Department of Justice if we feel patients are obtaining multiple prescriptions from multiple sources. Repeated reports of loss or theft indicated that you are not being responsible about your prescriptions, and this may result in termination from the practice.

Bring your medication bottles to each office visit.

Date: _____

Patient name: _____

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# Consent to Use Telemedicine

Patient's Name: _____

I am physically located in California. At the beginning of each telemedicine session, I will help my doctor to complete a check-in to assess the suitability of using telemedicine services by verifying my full name, my current location, my readiness to proceed, and whether I am in a situation conducive to private, uninterrupted communication. By signing this consent, I understand and agree:

1. My doctor is located in and licensed by the State of California. My doctor may not be able to prescribe medications for me and/or may not be able to assist me in an emergency situation when I am located in any other state or country. If I require medication, I may contact my doctor. If I require emergency care, I may call 911 or proceed to the nearest hospital emergency room for help.

2. I submit to the exclusive jurisdiction of the California state superior courts and agree that any claim, lawsuit, or other legal proceeding arising out of or relating to the telemedicine services provided by my doctor and my doctor's staff will be brought solely and exclusively in California state superior courts. I also agree that the interpretation of this consent will be exclusively governed by and construed in accordance with the laws of California.

3. My doctor believes that telemedicine services are appropriate for my medical condition and that I would benefit from its use despite its risks and limitations. While I may expect anticipated benefits from the use of telemedicine, no specific results can be guaranteed or assured.

4. If my doctor believes at any time that another form of services (for example, a traditional in-person consultation) would be appropriate, my doctor may discontinue telemedicine services and schedule an in-person consultation with my doctor or refer me to a healthcare provider in my area who can provide such services.

5. I have the right to withdraw consent to the use of telemedicine services at any time and receive in person healthcare services with my doctor.

6. I received an explanation of how the electronic communications technology will be used for the telemedicine services. I am comfortable with using electronic communications technology to communicate with my doctor and understand there are limitations to the technology which may require an in-person consultation.

7. I agree to have the necessary computer, equipment and internet access for my telemedicine communications. I also agree to arrange for a location with sufficient lighting and privacy and is free from distractions and intrusions during my telemedicine communications.

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8. The laws that protect privacy and the confidentiality of my medical information also apply to telemedicine. The medical information that is transmitted electronically by my doctor to me will be encrypted during transmission and will be stored only by my doctor or a service provider selected by my doctor. I understand the dissemination of any personally-identifiable images or information from the telemedicine communication to researchers or other healthcare providers will not occur except as required by federal or California state law.

9. I understand my risks of a privacy violation increase substantially when I enter information on a public access computer, use a computer that is on a shared network, allow a computer to "auto remember" usernames and passwords, or use my work computer for personal communications. I also understand it is my responsibility to encrypt medical information I transmit electronically to my doctor and my failure to use technical safeguards, such as encryption, increases my risks of a privacy violation.

10. No part of the encounter will be recorded without my written consent.

11. I have the right to access my medical information and obtain copies of my medical records in accordance with California law.

12. I understand that the telemedicine services provided to me will be billed to my health insurance company and that I will be billed for any patient responsibility as per my insurance.

I read and understand the information provided in this Consent to Use of Telemedicine. I discussed any questions I had with my doctor and all of my questions were answered to my satisfaction.

_____ _____

Date Patient's Signature

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