Viken S. Melkonian, M.D.
Heba F. Farag M.D.
26691 PLAZA DR. SUITE 160
Mission Viejo, CA 92691
Telephone (949) 364-5514

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Dr. Melkonian/Dr. Farag, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Dr Melkonian/ Dr. Farag's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr Melkonian/Dr. Farag reserves the right to revise its Notice of Privacy Practices at anytime.

With my consent, Dr Melkonian/ Dr. Farag may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Dr Melkonian/ Dr. Farag may mail to my home or other designated locations any items that assist the practice in carrying out TPO, such as patient statements as long as they are marked Personal & Confidential. I have the right to request that Dr Melkonian/ Dr. Farag restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Dr Melkonian/Dr. Farag's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. **If I do not sign this consent, Dr Melkonian/ Dr. Farag may decline to provide treatment to me.**

List any other person(s) that you give us permission to release your medical information to.

_____ _____
Name & relationship to patient phone number

_____ _____
Name & relationship to patient phone number

_____ _____
Signature of Patient or Legal Guardian Legal Guardian – Print the Patient's Name

_____ _____
Print Patient's Name Date

OFFICE POLICIES OF DR. FARAG\DR. MELKONIAN

Patients: Please **initial each line** after you have read each policy to indicate you **understand** each policy.

____ **WELL WOMAN EXAM** - This is to **NOTIFY you** that the guidelines have changed for pap & well woman exams **from every year to every 2-3 years** if at low risk and 3 consecutive test are negative. Therefore you may now be responsible for the cost of your annual well woman. **Please contact your insurance to find out what your individual plan covers.** The physician also has the right to bill for a consultation/office visit if they feel the visit has gone beyond the guidelines of a well woman visit.

____ **AUTHORIZATION** - If your insurance requires an authorization by your PCP, it is your responsibility to obtain the authorization prior to your visit. Otherwise you may be held accountable for the cost of the visit.

____ **PAYMENT/OUTSTANDING BALANCES** - All payments/copays are due at the time of service. Outstanding balances are due and payable prior to the physician's visit. It is our policy that all account balances be kept current. We can work with you on a payment plan if needed. Any other services, such as labs, radiology, etc. you may be responsibility for. Please contact your insurance plan for benefits.

____ **BILLING POLICY** - We will bill your insurance company at the time of service. If coverage is denied or there is a remaining patient balance for any reason, you will be responsible for the payment in full when you receive the statement.

____ **INSURANCE COMPANY DISPUTES** - it is your responsibility to negotiate payments or take up any disputes you may have with your insurance company.

____ **COVERAGE TERMS** - Your insurance policy is a contract agreement between you and your insurance company. You are responsible for knowing your terms and conditions of your policy. It is not the responsibility of Dr. Melkonian/Dr. Farags office to know your policy. As a courtesy, we attempt to verify eligibility and benefits. However, we are unable to obtain the exact details of payments until the claim is processed.

____ **COLLECTION POLICY** - If payment is not made when the monthly billing statement is received, you will be responsible for interest and penalties. Dr. Melkonian/Dr. Farags office subscribes to a collection company for any unpaid debt. Once your bill goes to collections you will be responsible for any attorney fees, interest and penalties. We cannot pull an account out of collections once it has been sent to collections. Ifyour account is sent to collections, there is a possibility that you may be discharged from the practice. We sincerely hope that this does not become necessary.

____ **RETURNED CHECKS** - There will be a $20 returned check fee applied to your bill for any returned checks.

____ **MISSED/CANCELLED APPOINTMENTS** - A $50 fee will be charged if the office is not notified 48 hours in advance of any cancelled/missed appointments. This fee is NOT covered by your insurance and therefore will not be billed to your insurance. It is your responsibility.

____ **LATE TO APPOINTMENTS** - If you are more than 15 minutes late to your appointment you will have to reschedule.

____ **COPY OF MEDICAL RECORDS OR DISABILITY PAPERWORK** - For medical records a written request must be received prior to the release of any records. A $40 charge will be required up front for the records. **For either medical records or disability paperwork please allow 1 week from receipt of the request to process.**

_____ _____

Print Name Initial

_____ _____

Patient Signature Date

Viken S. Melkonian, M.D. & Heba F. Farag, M.D.
26691 F[illegible]a Drive, Suite 160 Mission Vie[illegible], CA 92691

PATIENT REGISTRATION

Patient Name_____ Age_____ Date of Birth_____-_____-_____

SS #_____-_____-_____ Marital status: S M W SEP D

E-mail address _____

Street address_____

City/State/Zip_____

Home phone #_____ Cell #_____ Referred by_____

Spouses Name_____ SS#_____-_____-_____Date of birth____-____-_____

Emergency contact_____ Relationship_____

Cell #_____ Work #_____ Home # _____

PATIENT EMPLOYER INFORMATION

Employer name _____ Phone #_____ ext._____

Employer street address_____City/State/Zip_____

Patient's occupation_____ **OR Full time student / Part time student**

INSURED PERSON (IF NOT PATIENT)

Name _____ Date of birth_____

Relationship to patient_____ Phone #_____

Street address_____ City/State/Zip_____

Employer name & address_____

Insurance Company Name_____ ID #_____

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFIT

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in the place of the original. I hereby authorize Dr. Melkonian/ Dr. Farag to apply for benefits on my behalf for covered services rendered by his or by his order. I request that payment from my insurance company be made directly to Dr. Melkonian/ Dr. Farag.

I certify that the above information I have reported with regards to my insurance coverage is correct.

Date_____ Signature_____

DO NOT SIGN BELOW AT THIS TIME.....

Patient states all the above information has not changed as of

Date_____ Signature_____

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GENERAL MEDICAL INFORMATION

PATIENT NAME: _____ **DOB:** _____
Describe current medical problem/reason for today's visit: _____
Present Medications: _____
Allergies to Medication: _____
Other Allergies not related to Medication (e.g. soaps/laundry detergent):
_____
Other Physicians currently treating you: _____
Current or Past Medical Conditions: _____
List ANY surgeries or hospitalizations (include number of live births & miscarriages):
_____
Are you pregnant, nursing or planning for pregnancy? ☐ YES ☐ NO
Do you smoke? ☐ YES ☐ NO
Do you drink alcohol? ☐ YES ☐ NO How much per day? _____
Do you drink coffee? ☐ YES ☐ NO How many cups per day? _____
Are you under a lot of pressure/stress at home or work? ☐ YES ☐ NO
Please describe: _____

PATIENTS PERSONAL MEDICAL HISTORY

☐ **Chest pain/Pressure**	☐ **Asthma**	☐ **Kidney Disease**
☐ **Hypertension**	☐ **Dizzy Spells**	☐ **Shortness of Breath**
☐ **Heart Attack**	☐ **Cancer**	☐ **TB/LUNG DISORDER**
☐ **Stroke**	☐ **Diabetes**	☐ **Ulcers**
☐ **Headaches/Migraines**	☐ **Arthritis**	☐ **Skin Disorders**
☐ **Glaucoma**	☐ **Difficulty Breathing**	☐ **Hepatitis**
☐ **Allergies or Eczema**	☐ **Memory Loss**	☐ **Cataracts**
☐ **Depression**	☐ **Hemorrhoids**	☐ **Digestive Problems**
☐ **Blood in Stool**	☐ **Kidney Disease**	☐ **Frequent Urinary Inf.**

FAMILY HISTORY

High Blood Pressure	☐ **mother**	☐ **father**	☐ **grandparents**
Epilepsy	☐ **mother**	☐ **father**	☐ **grandparents**
Cancer	☐ **mother**	☐ **father**	☐ **grandparents**
Eczema/Psoriasis	☐ **mother**	☐ **father**	☐ **grandparents**
Heart Attack/Stroke	☐ **mother**	☐ **father**	☐ **grandparents**
Diabetes	☐ **mother**	☐ **father**	☐ **grandparents**
Asthma	☐ **mother**	☐ **father**	☐ **grandparents**
Hay Fever	☐ **mother**	☐ **father**	☐ **grandparents**