Eric G. Tepper, M.D.
Reed Vuong, D.O.
FAMILY MEDICINE
PERSONALIZED CARE

PATIENT INFORMATION FORM

PERSONAL INFORMATION

Full Name Email :

Address :

Date Of Birth : ____/____/____ **Gender** : ____

Address : ____

Mobile Number : ____ **Home #** : ____

Employer/School : ____ **Occupation** : ____

Marital Status : ☐ Single ☐ Married ☐ Divorced

Are You A Retiree ? : ____

Who can we thank for referring you? ____

EMERGENCY CONTACT

Contact Name : ____ **Home #** : ____

Relationship : ____ **Mobile #** : ____

PATIENT PORTAL

Would you like to sign up for our online patient portal? There you will be able to correspond with your physician and staff, view your labs and much more.

Name: ____

Email: ____

OFFICE USE ONLY

Date : ____

Membership Number : ____ :

Staff Name : ____

Eric G. Tepper, M.D.
Reed Vuong, D.O.
FAMILY MEDICINE
PERSONALIZED CARE

Eric Tepper, M. D.
Reed Vuong, D.O.

NEW PATIENT INTAKE FORM

PLEASE PRINT AND COMPLETE ALL ENTRIES

FIRST NAME	LAST NAME	DATE OF BIRTH
		_____/_____/_____

SEX	MOBILE PHONE #	HOME PHONE #	EMAIL ADDRESS

ADDRESS		
CITY	STATE	ZIP CODE

MARITAL STATUS ❑SINGLE ❑MARRIED	SPOUSE'S NAME	SPOUSE PHONE NUMBER
EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER

INSURANCE INFORMATION

DO YOU HAVE INSURANCE? ❑YES ❑NO	PRIMARY CARD HOLDER ❑SELF ❑SPOUSE. ❑PARENT. ❑OTHER_____	PRIMARY POLICY HOLDER NAME
PRIMARY INSURANCE COMPANY	PRIMARY ID NUMBER	PRIMARY GROUP NUMBER
DO YOU HAVE SECONDARY INSURANCE? ❑YES ❑NO	SECONDARY CARD HOLDER ❑SELF ❑SPOUSE. ❑PARENT. ❑OTHER_____	SECONDARY POLICY HOLDER NAME
SECONDARY INSURANCE COMPANY	SECONDARY ID NUMBER	SECONDARY GROUP NUMBER

PRESCRIPTION POLICY

- Please do not wait until your last pill to call for a refill. There is a 72 hour turn around for prescription refills. If you have not seen the Physician in six months, the prescription will be Denied.

PHARMACY NAME AND ADDRESS	PHARMACY PHONE NUMBER

PAYMENT POLICIES

- You are financially responsible for anything insurance does not cover. All copays are due and payable at each visit. The amount your insurance will allow and pay for and your financial responsibility is determined by your insurance company and the policy you have chosen. Your claim will be processed according to the benefits of your insurance plan. The deductible, co-insurance and co-pay are your financial responsibility. It is your responsibility to understand your insurance plan.
- $50 No Show Fee for any Missed Appointment that was not cancelled or rescheduled 24 hours prior to the appointment. Please be considerate and call at least 24 hours before your appointment if you cannot come in.
- If you are a private patient without insurance, all charges are due at the time of the visit. We do not send a statement to private pay patients.

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with_____and assign directly to Dr._____all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whither or not paid by insurance. I authorize the use of my signature of all insurance submissions.

The above named physician may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purposes of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

PATIENT SIGNATURE **DATE**

_____ _____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

Protected health information may be disclosed or used for treatment, payment, or healthcare operations:

- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? ☐ YES ☐ NO

May we leave a message on your answering machine at home or on your cell phone? ☐ YES ☐ NO

May we discuss your medical condition with any member of your family? ☐ YES ☐ NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____(PRINTNAME)

Signature: _____Date: _____

MEDICAL SERVICES AGREEMENT

Medical Consent: I consent to any treatments or procedures which may be performed on an outpatient basis (including emergency treatment or services), which may include but are not limited to medications, injections, taking of medical photographs, laboratory procedures, and/or x-ray examinations provided to me under the general and special instructions of the physicians, staff, or other health care providers of Eric G. Tepper, M.D. assisting my care.

Financial Agreement: I understand that all charges are due at the time of service. I agree to pay Eric G. Tepper, M.D. for all charges for healthcare services and professional services provided to me by physician professionals. Acceptable forms of payment include Cash, Visa, MasterCard, Discover, and American Express. If I am a non-insured patient, I agree to pay for my visit in full at the time of service. If Eric G. Tepper, M.D. is a participating provider with my insurance company, I understand that my co-pay, coinsurance, deductible, and/or any outstanding balances are due at the time of service. I understand that my insurance policy is a contract between myself and my insurance company, Eric G. Tepper, M.D. is not involved. In order for Eric G. Tepper, M.D. to file claims and accept payments from my insurance carrier, I understand that I must present current insurance information at each visit and that Eric G. Tepper, M.D. will need to verify my health insurance coverage. In the event that Eric G. Tepper, M.D. is not able to verify my insurance eligibility and benefits before my visit, I agree to pay for my visit in full at the time of service. A refund will be issued if my insurance pays for the visit. I also understand that I am financially responsible for any services not covered by my insurance company. When my spouse or a financial guarantor signs this agreement, the spouse or the financial guarantor shall be jointly and individual liable with me. Should my account(s) be referred to an attorney or a collection agency for the collection, the undersigned shall pay the actual attorney's fees (including costs) and collections expenses incurred in addition to the other amounts due. Unpaid accounts referred to outside agencies for collection shall bear interest at the current rate per year from the date of referral.

Insurance Authorization and Release: I request the payment of authorized benefits, including Medicare, and any other government sponsored program, private insurance, and any other health plans to be made to Eric G. Tepper, M.D. for any services furnished by that provider. To the extent necessary to coordinate my health care or determine liability for payment and to obtain reimbursement for services rendered, I authorize Eric G. Tepper, M.D. to disclose portions of or all of my records, including my medical records to any person or corporation which is or may be liable for all or any portion of Eric G. Tepper, M.D. charges, including but not limited to insurance companies, health care service plans, governmental agencies, or worker's compensation carriers. I authorize Eric G. Tepper, M.D. to act as my agent to help me obtain any required pre-certification as well as acting as my agent to help me obtain payment from my insurance companies. I authorize my insurance companies to give Eric G. Tepper, M.D. any information required to fulfill this function. This will remain in effect until revoked in writing. A photocopy of this assignment and release is to be considered as valid as the original.

Release of Medical Information: I hereby authorize Eric G. Tepper, M.D. to release any information in my chart to any practitioner, doctor, hospital, or medical institution to which I may be referred to assist in my care.

Notice of Privacy Practices: By signing this form, you acknowledge receipt of the "Notice Of Privacy Practices" of Eric G. Tepper, M.D. Our "Notice of Privacy Practices" provides information about how we may use and disclose your protected health information. 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 Eric G. Tepper, M.D. at (916)455-1155.

Personal Valuables: Eric G. Tepper, M.D. shall not be liable for the loss of or damage to any money, documents, jewelry, glasses, dentures, cell phones, cell phone chargers, head phones, ear buds, iPads, laptops, or other articles of unusual value and shall not be liable for loss or damage to any personal property. Eric G. Tepper, M.D. , A medical corporation and the patient or the patient's representative, hereby enters into this agreement. The undersigned certifies that he/she has read and agree to the foregoing, and is the patient, the patient's representative or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Signature: _____ Date: _____

Physician Patient 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 or 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 related 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 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 of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of 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: **Procedures and Applicable Law:** A demand for arbitration must communicate 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 rata 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 fees 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 the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

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

The parties agree that the provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of 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 once 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 arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days, or 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 Effective as of the date of first medical services.

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.

By: _____Patients Signature

Medical and Behavioral Health Providers
Confidential Exchange of Information Form

The exchange of information between medical and behavioral health providers encourages safe and efficient coordination of care for patients. **Please complete this form and send it to the requesting provider.**

Patient Full Name: (first, m.i., last)	**Patient Birth Date:** (mm/dd/yyyy)

Requesting Provider: **Medical / Behavioral Health Provider (Circle** provider type)

Provider name				Phone number
Street address	City	State	ZIP code	Fax number

Information Provided By: **Medical / Behavioral Health Provider (Circle** provider type)

Provider name				Phone number
Street address	City	State	ZIP code	Fax number

Patient diagnosis:

☐ ADHD / Behavior Disorder ☐ Substance Abuse ☐ Psychotic Disorder ☐ Bipolar Disorder
☐ Depressive Disorder ☐ Anxiety Disorder ☐ Eating Disorder ☐ Adjustment Disorder
☐ Personality Disorder ☐ Other: _____

Patient medications/herbal remedies:

☐ Antidepressant - SSRI / Tricyclic / MAOI **(please circle)** ☐ Antidepressant: (indicate name)_____
☐ Antipsychotic - Atypical / Typical **(please circle)** ☐ Lithium ☐ Clozaril
☐ Anticonvulsant/Mood Stabilizer ☐ Stimulant ☐ Anxiolytic
☐ Other (indicate medication name):_____

Expected length of treatment: ☐ <3 months ☐ 3-6 months ☐ 6-12 months ☐ >year

Coordination of care issues / other significant information regarding medical or behavioral health care:

_____

_____

Patient Authorization

I authorize the medical or behavioral health provider listed above to release information contained on this form to the practitioner listed, to facilitate the continuity and coordination of treatment. This consent shall expire one year from the date signed. I understand that I may revoke my consent at any time and understand that a revocation will not affect a disclosure made in reliance on this form prior to my revocation. I have read and understand the above information and give my authorization:

Patient - please check one:

☐ Release applicable information to my behavioral health practitioner
☐ Release applicable mental/behavioral health information to my medical practitioner
☐ I **do not** give my authorization to release any information to my medical practitioner

Patient signature:	**Date**

For Patient Records Applicable Under Federal Law 42 CFR Part 2

To the party receiving this information: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2.). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Guidelines for Use of My Personal Email

For the convenience of my patients, you may use my personal email to communicate with me. I hope you will review and follow the guidelines for email communications listed below. Please be aware that these guidelines may require modification as the need arises.

1. Please limit email content to the following topics:
    a. Non-treatment related healthcare issues (i.e. requests for general health information).
    b. Non-urgent medical questions and matters.
2. Please place the general topic in the subject line of your email so that it can be rapidly identified.
3. Communication with me utilizing email is done with the knowledge that I do not encrypt emails, that email is not a secure mode of communication, and that your information is exposed in a public domain and could be accessed. While we will treat your communication with the same care as we do your medical records and phone calls, please do not include sensitive information in your email. Specifically, do not include your social security number, financially sensitive information, or health information that you are not willing to expose to the risks of email. Your communication may be viewed by me, a covering physician, and, as necessary, medical assistants and other staff.
4. Please keep emails brief and concise, and clearly identify yourself by name in the body of the email.
5. Please be aware that while I will attempt to reply to emails as quickly as possible, my replies may take more than 1 business day. **Please do not include time sensitive requests in email, including urgent or acute matters, or new conditions. Please use the telephone for all urgent requests, and for all emergency conditions, dial 911 or go to the nearest emergency room.**
6. We will not be able to respond to medical emergencies via email.
7. Please understand that there will be times when I will not respond by email but will call you directly. Please also understand that we do not include attachments containing Protected Health Information in any email communications.

Email Informed Consent

I have carefully reviewed the preceding guidelines and hereby authorize **Eric G. Tepper, M.D.** to communicate with me via personal email regarding non-treatment related healthcare issues, and non-urgent medical questions and matters.

Signed _____

Date_____

Print Name_____

Email Address _____

Date of Birth _____