OFFICE OF DR DAVID GHAUSI
PATIENT INFO

DATE:_____

NAME:_____DOB:_____SSN:_____

ADDRESS:_____CITY_____STATE____ZIP CODE_____

PHONE:(CELL):_____(WORK):_____(HOME):_____

REFERRED BY: _____ MARITAL STATUS:

EMAIL ADDRESS:_____

OCCUPATION:_____EMPLOYER:_____

PREFERRED PHARMACY:_____
NAME, PHONE & ADDRESS

INSURANCE NAME & ID#:_____SUBSCRIBER NAME & DOB:_____

EMERGENCY CONTACT:_____PHONE:_____

The federal government requires that we collect the following information for your medical file. This information will be kept confidential and will not affect your medical care. This information will only need to be collected once at our office. We thank you for understanding

Please check one option in each column:

Race:

- ◯ I prefer not to answer
- ◯ American Indian of Alaskan
- ◯ Asian
- ◯ Black or African American
- ◯ Caucasian
- ◯ Native Hawaiian or Other Pacific Islander

Preferred Language:

- ◯ I prefer not to answer
- ◯ English
- ◯ Spanish
- ◯ other_____

Ethnicity:

- ◯ I prefer not to answer
- ◯ Hispanic or Latino
- ◯ Not Hispanic or Latino
- ◯ Other or undetermined

I GIVE MY PERMISSION FOR DR GHAUSI & STAFF TO SHARE MY PERSONAL MEDICAL INFO WITH:

_____
NAME & RELATIONSHIP TO ME

OR

SHARE MY PERSONAL INFO WITH ONLY ME (check here) ☐

We send SMS(text) messages to remind you of your appointments. Do you give us your permission to contact you in this way:) No

Release of medical information: I authorize the release of any medical information deemed necessary to verify benefits or process claims for services rendered to me by Dr. David Ghausi.
Assignment of benefits: I authorize my insurance carrier to make payment directly to Dr. David Ghausi on my behalf for services provided to me. I understand that by signing this agreement, I accept financial responsibility for the deductible, co-insurance & non-covered services/charges.

Other:_____

PATIENT SIGNATURE:_____DATE:_____

IF MINOR:_____DATE:_____
Parent(guardian) signature

David Ghausi D.O., Inc.
Fellow, American College of Obstetrics and Gynecology
2220 Lynn Road, #302 Thousand Oaks, CA 91360 Ph: 805.497.0244 Fax: 805.497.0844

OFFICE POLICIES

- We make every effort to stay on schedule, barring any emergencies. Please arrive at your appointed time. We ask that you give a 24-hour advance notice of appointment cancellations.

- Telephone messages of a routine nature will be answered within 24 hours. We will make two attempts during this 24-hour period to reach you. If you have not heard from us within this 24-hour period, please call again.

- Prescription refills will be approved ONLY if your are up-to-date on your pap smear, mammogram, and blood tests. There is a 24-hour processing time for all refill requests. Therefore, please carefully manager your prescription refill status.

- Please be prepared to pay your deductible amounts, copays, & co-insurance balances on the day of your visit. There is a charge for returned checks.

- Medical records are the property of this office. Your record is always available to you upon your formal request. If you desire a full copy of your record, there is a $25 fee which covers my costs. Please remember that I am required by law to maintain your record here even after your copy is given to you. Also, it must be understood that natural calamities, such as floods, rain, earthquake & fire may accidentally damage a part or your entire record. Every effort is made to prevent this occurrence.

- We make every effort to report test results to you as soon as possible. However, if you do not hear from me or my staff within a week of your testing, please call the office for your results. Please understand that mammogram and bone density results may take longer.

- Treatment of infections(vaginal or bladder) will require an office visit. My staff will work you into our schedule the same day if necessary. Therefore, please attempt to contact us first thing in the morning to give us ample time to accommodate you.

I have read these policies listed above. I understand them and agree with them.

_____ _____

SIGNATURE DATE

_____ _____

PARENT OR GUARDIAN SIGNATURE DATE

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PATIENT PARTNERSHIP PLAN

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your *best possible health* requires a "partnership" between you and your doctor. As your "partner in health", we ask you to help us in the following ways:

1. ***Schedule visits with my doctor for routine physical exams and other recommended health screenings.***

I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, & personal and family history. I understand I will need to complete these recommended health screenings (mammograms, immunizations, pap smears etc). These health screenings are tests that can help detect life-threatening diseases and conditions. If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

2. ***Keep follow up appointments and reschedule missed appointments.***

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her the chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

3. ***Call the office when I do not receive the results of labs and other tests.***

I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my results.

4. ***Inform my doctor if I decide not to follow his or her recommended treatment plan.***

I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medications, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that not following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide not to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, at any time, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

Patient signature Date Provider signature

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I have reviewed Dr. Ghausi's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document (available in its entirety in the office).

_____
PATIENT NAME

_____
SIGNATURE OF PATIENT OR PATIENT REPRESENTATIVE

_____
PRINT NAME OF PATIENT OR REPRESNTATIVE

_____
RELATIONSHIP TO PATIENT

_____
DATE