

Welcome to my office!

Please print and fill out the following forms in order to expedite registration at your appointment. Please plan on arriving 25 minutes prior to your scheduled appointment with your forms and insurance information.

My office is located in the Batavia Woods Medical Complex off of La Veta in building 805. I share office space with two other physicians. I am located on the first floor in Suite 101. My phone number is 714-997-9595.

If you are unable to keep your appointment, please kindly notify us at least 24 hours prior in order to allow other patients to utilize your appointment time.

I look forward to meeting with you!

Warm regards,

Lisa M. Valle, D.O.

Diplomate of The American College of Obstetrics & Gynecology

Attached forms:

- Patient Information Form
- Authorized Methods of Communication
- Consent for Release of Information
- Notice of Privacy Practices
- Financial Policy
- Letter Regarding On-Call physician
- Records Release Authorization

PATIENT INFORMATION FORM

(Please Print)

Today's date:			PCP:			
PATIENT INFORMATION						
Patient's Last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		Social Security No.:	Birth date:	Age:	
Street address:				Home phone no.: ()		
City:		State:	Zip:	Cell phone no.: ()		
Occupation:		Employer/Address:		Employer Phone #: ()		
Chose Doctor because/referred to office by (please check one box):			<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance plan	<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Internet	<input type="checkbox"/> Dr Valle's website	<input type="checkbox"/> Other		
California Driver's License #:						

INSURANCE INFORMATION					
(Please give your insurance card to the receptionist)					
Person responsible for bill:		Birth date:	Address (if different):	Home phone #: ()	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Subscriber's Name:		Subscriber's S.S. #:	Birth Date:	Group #:	Policy #:
Subscriber Address:					
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
Name of secondary insurance (if applicable):			Subscriber's Name:	Group #:	Policy #:
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					

IN CASE OF EMERGENCY		
Relative/Friend to contact in case of emergency		
Name:	Home #:	Cell #:
Relationship to patient?		

The above information is true to the best of my knowledge. I hereby authorize my insurance benefits be paid directly to Lisa M. Valle, D.O. I also authorize Lisa M. Valle, D.O. to release any information required to process my claims. I understand that I am financially responsible for any balance/charges not covered by the assignment. I understand finance charges may be applied to any unpaid balance after ninety (90) days.

I accept responsibility for all charges incurred in the medical evaluation and health care of the above named patient.

I understand that ongoing primary medical care is the responsibility of the patient: it is not the responsibility of Lisa M. Valle, D.O.

Signature

Date

Authorized Methods of Communication

To protect your privacy we need your permission to leave a message if you are unavailable. Is there a phone number/email on which personal health information could be left as a message recording/email in the event we need to contact you regarding test results or other instructions from the doctor? Of note, Dr Valle often mails/emails normal results.

Please check/circle all that apply.

- **Home Telephone #:** _____
Do we have permission to leave a detailed message...
with a person? Y N
On your answering machine/voicemail? Y N
Or Do we have permission to leave a call back number only? Y N

- **Cell Phone #:** _____
Do we have permission to leave a detailed message on your voicemail? Y N

- **Work telephone #:** _____
Do we have permission to leave a detailed message on your personal voice mail? Y
N
Or Do we have permission to leave a call back number only? Y N

- **Personal email address:** _____
(Of note, Dr. Valle will not send emails to work email addresses).
Do we have permission to send you detailed results via email? Y N

Do we have permission to send you results via mail (i.e. US postal service) to your home address listed on your *Patient information sheet*? Y N

Signature

Print Name

Date

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT,
PAYMENT, AND HEALTHCARE OPERATIONS

I, _____, hereby, authorize Lisa M. Valle, D.O. to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Dr. Valle can refuse to treat me.

I have been informed that Lisa M. Valle, D.O. has prepared a Notice of Privacy Standards ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying my practitioner, in writing, but if I revoke my consent, such revocation will not affect any action that my practitioner took before receiving my revocation.

I understand that Lisa M. Valle, D.O. has reserved the right to change their privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that Lisa M Valle, D.O. restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that Lisa M Valle, D.O. does not have to agree to such restrictions, but that once such restrictions are agreed to, they must adhere to such restrictions.

Signature of patient/patient's representative:

Printed Name of patient/patient's representative:

Relationship to the patient: _____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan or from other third party payors that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of the practice of Lisa M. Valle, D.O.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable disease to the state's public health department.

Appointment reminders. Your health information will be used by our staff to send you appointment reminders. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of our information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the front office receptionist. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns. If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint. You also may file a complaint with the Secretary of Health and Human Services.

Financial Policy

To Our Patients:

Thank you for selecting our office for your medical care. We are committed to providing you with the best possible care. Your clear understanding of our Financial Policy is important to our professional relationship. In order to prevent any misunderstanding concerning the responsibility for payment for medical services provided to our patients, the following information is provided.

The patient (or the guarantor) is responsible for payment for services provided by a physician from our office at the time of service. We accept CASH & CHECKS ONLY. The co-pay is expected at the time of service, we do not bill for them. However, should certain benefits not be covered by your plan, you will be responsible for payment of these services. If a balance becomes your responsibility, the amount is due in full within 30 days & if not, it will be assigned to an outside collection agency. Out of area patients will be required to pay in full at the time of service. It is the patient's responsibility to know the services that are and that are not covered by their insurance.

HMO/PPO or other Contracted Insurance Coverage

If you have insurance coverage through a company that we are contracted with, we require a copy of your insurance card and payment of your deductible and/or co-pay at the time of service. Failure to provide this may require you to pay at time of service in full. Please be prepared to pay your co-pay in full at the time of service on each visit.

Medicare

Our physicians are participating Medicare providers. Office visits to a doctor are covered under part B of the Medicare program. Medicare pays 80% of their allowable charges after you pay your annual deductible for calendar year. If you have supplemental insurance we require a copy of your insurance card.

I have read all the information above and agree that regardless of my insurance status I am ultimately responsible for the balance on my account for any professional services rendered.

In the event, my insurance company is billed I authorize payment of medical benefits to be paid directly to the physician that rendered services. A photocopy of this agreement shall be considered as effective and valid as the original.

Non-covered medical services are the responsibility of the patient.

If a check is returned from the bank for non-payment (i.e. nonsufficient funds, account closed, payment stopped, etc.), there will be a bank fee applied to my account in addition to the amount of the returned check. I will be required to pay in cash at the time of serve for future visits.

In the event any lawsuit or action is brought to collect this account or any portion thereof I agree to pay a reasonable sum for attorney's fee in addition to costs and disbursement provided by statue.

Signature/Responsible Party: _____

Date: _____

Lisa M. Valle, D.O.

**Obstetrics/
Gynecology**

Dear Patient,

Every patient that I have an opportunity to care for is entitled to and will receive the best care that I can provide.

However, between medical seminars, meetings, and periodic vacations, it is humanly impossible for any physician to be available 24 hours a day, 365 days a year. I may not be available when you call. This does not mean that you will not receive the medical attention you require.

When I am not available, another equally qualified doctor will provide medical care for you. These arrangements help assure us that you will be cared for by a physician who is able to function at peak efficiency.

The on-call physician will provide care for labor and delivery, gynecological problems, and emergency room visits.

In case of emergency, please call my office phone number and the exchange will contact you with the on-call physician. If this is an emergency and your call is not returned immediately, proceed directly to the hospital or call 911. In cases of non-emergency calls, the on-call physician will call you back in a reasonable amount of time.

When calling the physician for a problem, please have the pharmacy phone number ready in case a medication needs to be prescribed.

If you have any questions, please do not hesitate to ask me at the time of your visit.

Sincerely

,

Lisa M. Valle, D.O.

I ACKNOWLEDGE RECEIPT OF THIS LETTER.

Signature: _____

Print Name: _____

Date: _____

Lisa M. Valle, D.O.
Obstetrics & Gynecology
RECORDS RELEASE AUTHORIZATION

TO: _____
Doctor or Hospital

Address

Address

Phone/Fax #

I hereby authorize and request you to release to:

Lisa M. Valle, D.O.
805 West La Veta, Suite 101
Orange, California 92868
Office: 714-997-9595/Fax: 714-997-1098

The following records in your possession:

Name: _____

Date: _____

Address: _____

Signature: _____