ERNEST CHENG, D.O.
3031 TELEGRAPH AVENUE, SUITE 241, BERKELEY, CA 94705
PHONE 510-549-2038 FAX 510-549-2690
1081 MARKET PLACE, SUITE 600, SAN RAMON, CA 94583
PHONE 925-237-9808 FAX 925-237-9809

PATIENT REGISTRATION

NAME_____ D.O.B._____

ADDRESS, CITY, ZIP CODE_____

CELL PHONE_____ HOME PHONE_____

EMAIL ADDRESS_____ MARITAL STATUS_____

SOCIAL SECURITY #_____ GENDER_____

WHO REFERRED YOU TO THIS OFFICE?_____

PRIMARY CARE DOCTOR_____

PRIMARY CARE DOCTOR ADDRESS_____

PRIMARY CARE DOCTOR PHONE#_____ FAX#_____

INSURANCE INFORMATION

PRIMARY INSURANCE_____ CO-PAY_____

SECONDARY INSURANCE_____ OTHER INS._____

IS THIS THE RESULT OF AN ACCIDENT? **YES or NO** DATE OF ACCIDENT_____

IS THIS WORK RELATED? **YES or NO** DATE OF INJURY_____

WORKERS COMP INSURANCE CO._____ CLAIM #_____

ADRESS_____

NAME OF ADJUSTER_____ PHONE#_____ FAX#_____

NAME OF ATTORNEY_____ PHONE#_____ FAX#_____

ADDRESS_____

ASSIGNMENT AND RELEASE

I hereby authorize my insurance company to pay benefits to Ernest Cheng, DO. I am financially responsible for non-covered services. I also authorize to release any information required to process this claim.

SIGNATURE_____ DATE_____

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LAST NAME_____ **FIRST NAME**_____

AGE_____ **DATE**_____

PRIMARY COMPLAINT_____

_____

_____

Give the details of how, when, where, time and place of injury / symptom onset_____

_____

Please give the following details:

Location of the pain as well as where it goes (such as down the arm or leg)_____

_____

Character of the pain (dull, aching, sharp, burning, etc.)_____

What activities cause the pain_____

What you can do to alleviate the pain_____

How are your activities limited due to the pain_____

Briefly outline previous medical treatment for this injury / symptom, such as medications, physical therapy, surgery, or alternative medicine treatments_____

_____

Have you had a previous injury in the same location of the injury for which you will be treated today? If so, please explain the details of the previous injury._____

_____

Current Medications:

Name	Dose	How Often	Last Taken

_____

_____

Allergies:

Food_____

Respiratory_____

Medications (describe reactions)_____

Please list serious medical illnesses requiring hospitalization_____

_____

Please list any current chronic medical conditions_____

_____

List all previous surgeries_____

_____

Women:

Have you ever been pregnant?_____ How many times?_____

Number of live births_____ Any complications with pregnancies or deliveries_____

Do you smoke?_____ Packs per day_____ Do you drink?_____ Drinks per week?_____

Have any of these conditions ever been a significant problem?

___Severe Headaches
___Visual Problems
___Cataracts / Glaucoma
___Arthritis
___Hearing Deficit
___Trouble Chewing or Swallowing
___Thyroid Problems
___Difficulty Breathing
___Asthma
___Chronic Bronchitis
___Emphysema
___Chest Pain
___Heart Disease
___Heart Attack
___Abdominal / Stomach Pain
___Diabetes
___Liver Disease
___Jaundice
___Hepatitis
___Kidney Infections
___Kidney Stones
___Bladder Infections
___"Female" Problems
___Prostate Problems

NOTICE OF PRIVACY PRACTICES

You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to: Medical Records Department, Ernest Cheng, D.O., PC, 3031 Telegraph Avenue, Suite 241, Berkeley, CA 94705.

You may ask us to amend your health information if you believe it is not correct or complete, as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to: Medical Records Department, Ernest Cheng, D.O., PC, 3031 Telegraph Avenue, Suite 241, Berkeley, CA 94705. You must provide us with a reason that supports your request for amendment.

Right to a copy of this notice: You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at anytime. To obtain a copy of this Notice, contact our front desk receptionist.

Right to file a complaint: If you believe your privacy rights have been violated, you may file a complaint with our practice. To file a complaint with our practice, contact Privacy Officer, Ernest Cheng, D.O., PC, 3031 Telegraph Avenue, Suite 241, Berkeley, CA 94705. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Right to provide an authorization for other uses and disclosures: Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Privacy Officer, Ernest Cheng, D.O., PC, 3031 Telegraph Avenue, Suite 241, Berkeley, CA 94705

I hereby acknowledge that I have been presented with a copy of Ernest Cheng, D.O., PC's Notice of Privacy Practices.

_____ _____

Print Name of Patient Patient Signature

_____

Date

NOTICE OF PRIVACY PRACTICES

To our patients: This notice describes how health information about you (as a patient of this Practice) may be used and disclosed, and how you can get access to your health information. Please review it carefully. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy: Our Practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information and to provide you with the following information.

Use and Disclosure of Your Health Information in Certain Special Circumstances
The following circumstances may require us to use or disclose your health information:
To public health authorities and health oversight agencies that are authorized by law to collect information.

Lawsuits and similar proceedings, in response to a court, or administrative order, if required to so by a law enforcement officer.

When necessary, to reduce or prevent a serious threat to your health and safety, or the health and safety of others. We will only make disclosures to a person or organization able to help prevent the threat.

If you are a member of the U.S., or foreign military forces (including veterans), and if required, by the appropriate authorities.

To federal officials, for intelligence, and national security activities, authorized by law.

To a correctional institution, or law enforcement official, while under the custody of a law enforcement official.

For Workers Compensation and similar programs.

If required to do so by a law enforcement official.

Your rights regarding your health information: Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

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AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

I hereby authorize _____ to release the following

Medical information:

********* **to 3031 TELEGRAPH AVENUE, SUITE 241, BERKELEY, CA 94705** *********

********* **to 5720 STONERIDGE MALL ROAD, SUITE 250, PLEASANTON, CA 94588** *********

This release is effective for 6 months from the date of execution; however, it may be revoked by me at anytime by providing notice in writing to the above named party.

Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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APPOINTMENT CANCELLATION POLICY

An appointment constitutes an agreement between the physician and the patient. Patients are expected to come for an appointment as scheduled. Our office requires a 48-hour advance notice of appointment cancellation or appointment change. Otherwise, a fee of will be billed to you, not to your insurance company, for the time of the failed appointment. New patient failed appointment will be billed $75.00 and follow-up failed appointment will be billed $50.00. Our office understands that emergencies arise and one missed appointment will be allowed in any twelve-month period before a charge is made to the patient.

MEDI-CAL PATIENTS: Medi-Cal does not permit charging patients for missed appointments, however; two missed appointments in any six-month period requires contact from the patient's primary physician before another appointment will be scheduled. If three appointments are missed the patient will be terminated from our care.

Signature_____ Date_____

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NARCOTIC AGREEMENT

We have agreed that narcotics can help you deal with chronic pain. I, Ernest Cheng, D.O., have agreed to provide ongoing narcotic prescriptions for you. In order to carry out this plan, there are several things you must understand:

1. Narcotics do not cure pain conditions and may cause other problems.
2. The main goal of narcotic therapy is to improve your ability to function. We do NOT necessarily expect that you will become pain-free.

Patient Responsibilities:

1. Only one physician may prescribe narcotics at any time. Having more than one prescriber will constitute grounds for immediate dismissal from this practice.
2. You must select one pharmacy for your medication(s).
3. You agree to take your medication(s) as prescribed.
4. You are responsible to take care of your medication(s). If you lose, destroy, or have medication(s) stolen, early refills ARE NOT guaranteed.
5. You must continue your relationship with your primary care doctor. Once we have determined a stable medication dose, your primary care doctor will need to provide medication refills. (EXCEPTION: If you are being seen under worker's compensation and if your settlement includes ongoing medical care, we can continue to provide medication refills as long as you are seen in this office at least every three months.)
6. Forged or abused prescriptions are grounds for immediate dismissal from this practice.
7. Treatment discussions can only occur during scheduled appointments.
8. You must contact the office to request a refill 2-3 business days before you run out of medication so that we have time to write prescription refills.
9. You agree to allow and provide (urine) samples for drug screening.
10. You agree that we can discuss your case with caregivers and physicians who are involved with your care.

Understanding: If I do not carry out the responsibilities noted above, I may be discharged from this practice. The standard procedure is to be given a tapering dosage of medication and a reference list of other community pain physicians. This office is not responsible for finding another pain doctor for me.

Patient Signature_____ Date_____

Print Patient Name_____