Del Mar M.E.D.
12395 El Camino Real, Ste. 200
San Diego, CA 92130
PH: 858-755-6647 F: 858-755-5947
www.DelMarMed.com

Dina Massry, M.D.
Jeff Eaton, M.D.
Jennifer Eastlack, M.D.

DATE _____/_____/_____

NAME: LAST_____FIRST_____ MIDDLE INITIAL_____

PREFERRED NAME _____

DATE OF BIRTH _____/_____/_____ **SEX** ☐ F ☐ M **SOCIAL SECURITY NUMBER** _____ /_____ /_____

ADDRESS_____

CITY_____STATE_____ZIP_____

HOME PHONE_____ CELL_____WORK_____ EXT_____

BEST NUMBER TO REACH YOU: _____PERMISSION TO LEAVE MESSAGE: **HOME** ☐ YES ☐ NO **CELL** ☐ YES ☐ NO

EMAIL (Provides access to Patient Portal):_____

MARITAL STATUS: ☐ SINGLE ☐ DIVORCED ☐ PARTNER ☐ WIDOWED ☐ MARRIED (spouse name) _____

ETHNICITY_____ PRIMARY LANGUAGE_____

PHARMACY

NAME_____**LOCATION**_____

PHONE (_____) _____-_____ FAX (_____) _____ -_____

PRIMARY CARE DOCTOR_____ PHONE_____

REFERRING PHYSICIAN_____PHONE_____

RESPONSIBLE PARTY (IF MINOR) ☐ PARENT ☐ GUARANTOR RELATIONSHIP (other than parent)

NAME _____ ADDRESS_____

CITY_____ STATE_____ ZIP_____HOME PHONE _____

EMERGENCY CONTACT

NAME: LAST_____ FIRST_____RELATIONSHIP_____

ADDRESS_____CITY_____STATE_____ZIP_____

HOME PHONE NUMBER (_____) _____ -_____WORK / CELL PHONE NUMBER (_____) _____-_____ EXT._____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN:_____

PLEASE SIGN THE FOLLOWING PAGES ⇨

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RELEASE/ASSIGNMENT/ACKNOWLEDGEMENT

I consent to medical examination, treatment, and diagnostic studies advised by the physician. I authorize insurance benefits be paid directly to the practice. Del Mar M.E.D. will offer what they feel, in their medical opinion, is medically necessary for my healthcare.

I HEREBY AUTHORIZE DEL MAR M.E.D. TO RELEASE PERTINENT INFORMATION REGARDING MY CARE TO OTHER PHYSICIANS AND/OR INSURANCE COMPANIES HOLDING POLICIES ON ME.

I authorize my insurance company to directly remit payment to Del Mar M.E.D. for medical and surgical services provided.

I understand some services advised by my doctor may or may not be covered by insurance. **I understand that I am financially responsible for any outstanding balance and will promptly pay this in full within 30 days of receiving a bill.** I understand accounts 120 days past due will be transferred to a third party collections agency and that I will be responsible for any and all fees accosicated with this transfer.

I UNDERSTAND THAT BY NOT PROVIDING THE OFFICE WITH ALL INFORMATION REQUESTED AND/OR COPIES OF MY INSURANCE CARD(S) AT TIME OF SERVICE, THIS COULD CAUSE A DELAY IN THE PROCESSING OF MY CLAIM AND I COULD CONSEQUENTLY RECEIVE A BILL FOR THESE SERVICES.

My signature below indicates my acceptance/understanding of the above statements.

NOTICE TO CONSUMERS
Medical doctors are licensed and regulated by the Medical Board of California
(800) 633-2322
www.mbc.ca.gov

Signature of patient or parent/guardian: _____Date: _____

PLEASE SIGN THE FOLLOWING PAGES ⇨

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. 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. We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs
9. .

Your rights regarding your health information

1. *Communications:* You can request that your physician's office communicate with you about your health and related issues in a specified manner or at a certain location. For instance, you may request that we contact you at home, rather than work. We will accommodate reasonable requests.
2. 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 members and friends. We are not required to agree to your request; however, if we are bound by our agreement except when otherwise required by the law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decision about you, including patient medical and billing records, but not including psychotherapy notes. You must submit your request in writing to Jeff Eaton, M.D., Dina Massry M.D. or Jennifer Eastlack M.D., Scripps Medical Building, Suite 200, 12395 El Camino Real, San Diego, CA 92130.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and 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 Jeff Eaton, M.D., Dr.Dina Massry, M.D., or Jennifer Eastlack M.D., Scripps Medical Building, Suite 200, 12395 El Camino Real, San Diego, CA 92130. You must provide us with a reason that supports your request for amendment.
5. 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 any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, please contact our office manager at 858-755-6647. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. If a disclosure is made for any reason other than treatment, payment or operation, you have the right to an account of those 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 our Office Manager at 858-755-6647. We reserve the right to revise this notice at any time without notification.

I hereby acknowledge that I have been presented with a copy of Jeff Eaton, Dina Massry and/or Jennifer Eastlack M.D.'s Notice of Privacy Practices.

SIGNATURE OF PATIENT OR PARENT/GUARDIAN:_____Date:_____

Patient's Name (please print): _____

PLEASE SIGN THE FOLLOWING PAGE ⇨

NO SHOW/MISSED APPOINTMENT POLICY

We, at Del Mar M.E.D., understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-hour notice for a routine appointment and 48-hours for a surgical appointment). You can cancel appointments by calling the following numbers: 858-481-3376 or 858-755-6647.

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to arrive to their visit on time. As a courtesy, an appointment reminder text to you is made/attempted one (1) business day prior to your scheduled appointment. However, it is the responsibility of the patient to make a record of their scheduled appointment and to arrive promptly for them.

PLEASE REVIEW THE FOLLOWING POLICY:

1. Please cancel your appointment with at least a 24 hour notice for a routine appointment. Less than a 24-hour cancellation will result in a $50 fee. In addition, a credit card will be held on file to schedule any subsequent appointments.
2. Please cancel your appointment with at least a 48 hour notice (BUSINESS DAYS) for a surgical appointment. There is a surgical waiting list to see the surgeon at Del Mar M.E.D. and whenever possible, we fill cancelled spaces to shorten the waiting period for our patients. Less than a 48-hour cancellation will result in a **$250** fee. In addition, a credit card will be held on file to schedule any subsequent appointments.
3. If a patient presents to the office late for a scheduled appointment with our providers, the patient may be asked to reschedule their appointment. When a patient arrives late, the time spent with the patient is minimized and does not allow for a full assessment. It also disrupts the schedules of our providers and other patients.

I have read and understand Del Mar M.E.D. No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify Del Mar M.E.D appropriately if I have difficulty keeping my scheduled appointments.

SIGNATURE OF PATIENT OR PARENT/GUARDIAN:_____Date:_____

Patient's Name (please print): _____

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CONSENT FOR ADDITIONAL OFFICE PROCEDURES AND PATIENT RESPONSIBILITY

There are a number of procedures performed in our office which are necessary as either part of your diagnostic work-up and/or as treatment. On your bill, you may see separate charges in addition to your office visit charge. Often these have billing codes that are listed as "surgery' and may seem confusing on the bill. All the charges are submitted to your insurance, but not all may be covered equally. These procedures will only be done if it is determined to be necessary for the treatment and/or evaluation of your condition. Prior to doing any of these procedures your doctor will make you aware. These procedures are as follows, but not limited to:

Nasal Endoscopy
Fiberoptic Laryngoscopy
Biopsy of mass/lesion
Cerumen (wax) impaction removal
Liquid Nitrogen
Injections

Additionally, due to policy provisions in your contract with your insurance carrier, we are obligated to collect all patient responsibility balances.

If your insurance policy has provisions such as deductibles, coinsurances, or copayments please note that these are provisions that have been agreed to between you and your carrier. We cannot legally discount fees after their submission on your behalf to your carrier.

If we are networked with your carrier, we have an additional contractual obligation to collect the balances as outlined by your carrier. Writing off patient responsibility balances could jeopardize our contract with your carrier.

If a portion of your fees are applied to an annual out-of-pocket maximum, and we do not collect that fee, your out-of-pocket maximum has not been correctly calculated.

We sincerely regret if any of these regulatory provisions cause you any inconvenience, but we are bound by all provisions of insurance policy and federal law. Please feel free to contact us with any questions you may have or any assistance you may require to fully understand these provisions.

Please sign and print name, that you have read and understand this explanation

SIGNATURE OF PATIENT OR PARENT/GUARDIAN:_____Date:_____

Patient's Name (please print): _____