



## BILLING POLICIES AND PROCEDURES

1. Appointments not cancelled 24 hours prior to your scheduled time will be charged \$50 per appointment.
2. We provide courtesy billing for patients with accurate insurance billing information including copy of insurance cards, claims address and claim form if required. If this information is not given at the time of service, it will be the patient's responsibility to pay for the services rendered.
3. If you have a change in insurance, it is your responsibility to alert our office of this change. If you fail to do this before services are rendered, it will be your responsibility to pay for the services.
4. It is your responsibility to understand your insurance policy and its benefits. Make sure you understand how it works in regard to co-pays, deductibles and co-insurance. **Please make sure you know what is and what is not covered.**
5. Insurance companies do not always pay the entire bill. It is to be understood that any balance after payment by the insurance company will be billed to you and should be paid promptly or an arrangement made.
6. Your insurance is a contract between you, your employer and the insurance company.
7. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover. In the event the insurance does not cover the payment for services, they are the patient's responsibility.
8. It is your responsibility to check with your insurance company if prior authorization is required.
9. HMO PATIENTS: It is your responsibility to make sure that:
  - a. Your policy is effective for the IPA you have selected and the PCP you have chosen is correct on your card.
  - b. Your co-pay is paid at the time of service, if you have a co-pay.
  - c. If you have services done and we are not the PCP listed, you may be liable for the bill.
10. We do accept assignment of benefits from Medicare. As a courtesy we will bill your secondary insurance. Any balance not covered will be the patient's responsibility.
11. CASH PATIENTS: There may be charges in addition to your initial office visit charge for procedures and surgeries.
12. **All** co-pays and deductibles are payable at the time of service.
13. **All** accounts are due and payable within 60 days from the date of service unless arrangements have been made.

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Signature of Patient/Responsible Party

Date

## INSURANCE INFORMATION & ELIGIBILITY GUARANTEE

Patient's Name \_\_\_\_\_ DOB \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ DOB \_\_\_\_\_

Contract Name (i.e. Blue Cross...) \_\_\_\_\_

Medical Group (if HMO) (i.e. Regal, IEHP...) \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

I understand that if the above is not true, or if I am ineligible under the terms of my health plan and/or employer's group's Medical and Hospital Subscriber Agreement, I am financially responsible for all charges for services rendered. Additionally, assuming my eligibility for benefits is not established as set forth above, I agree to pay for all services within 60 days of receiving a bill from this office.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
DOB

## INFORMATION FOR YOUR PHYSICIAN

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_  
Place of Birth \_\_\_\_\_ Race/Nationality of Parents \_\_\_\_\_  
Religion \_\_\_\_\_ Education \_\_\_\_\_ Age on completion \_\_\_\_\_  
Occupation \_\_\_\_\_ For how long? \_\_\_\_\_  
Where and when have you lived or traveled outside the U.S. and Canada? \_\_\_\_\_

	Living	Age or Age at death	Present health or cause of death
Father	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Mother	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Spouse	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Present marriage length	_____		Previous marriage length _____
Brothers	# Living _____	Health _____	
	# Dead _____	Cause of death _____	
Sisters	# Living _____	Health _____	
	# Dead _____	Cause of death _____	
Children	# Living _____	Health _____	
	# Dead _____	Cause of death _____	

Please circle illnesses which have occurred in any of your blood relatives.  
Diabetes      Bleeding Tendency      Kidney Disease      Tuberculosis      Heart Disease  
Stroke      High Blood Pressure      Nervous Illness      Allergy      Cancer

Please circle illnesses or conditions you have had.  
Diabetes      Glaucoma      Heart Trouble      Syphilis      Vein Trouble      Cancer  
Asthma      Jaundice      Gonorrhea      Bleeding Tendency      Tuberculosis  
Pneumonia      Kidney Disease      Rheumatic Fever      Nervous Disorder

Please list other illnesses not requiring operation for which you were hospitalized.

\_\_\_\_\_

Have you had serious injuries, broken bones, etc.? If yes, please list. \_\_\_\_\_

\_\_\_\_\_

Have you had allergy or sensitivity to medicines or other substances? If yes, please describe. \_\_\_\_\_

\_\_\_\_\_

Do you use tobacco now? \_\_\_\_\_ In the past? \_\_\_\_\_ Amount \_\_\_\_\_ For how long? \_\_\_\_\_  
Do you use alcoholic beverages? \_\_\_\_\_ Type \_\_\_\_\_ Amount \_\_\_\_\_ For how long? \_\_\_\_\_

Please check the diseases against which you have been immunized.  
 Smallpox  Tetanus  Typhoid  Polio  Influenza  Other \_\_\_\_\_

Please list previous operations, giving dates, hospital where performed, and the name of the surgeon. \_\_\_\_\_

\_\_\_\_\_

Please list previous x-ray therapy or similar treatment. \_\_\_\_\_

\_\_\_\_\_

Medications \_\_\_\_\_

\_\_\_\_\_

Menstrual History: last period \_\_\_\_\_ Periods are  Regular  Irregular  
# of Pregnancies \_\_\_\_\_ # of Miscarriages \_\_\_\_\_

Have you take Cortisone-type drugs? \_\_\_\_\_ Oral Contraceptives? \_\_\_\_\_

Have you received a blood transfusion? \_\_\_\_\_ Date \_\_\_\_\_

Your weight dressed \_\_\_\_\_ How long have you been this weight? \_\_\_\_\_

Please write the main reason you came to the office \_\_\_\_\_

Provider's Signature \_\_\_\_\_ Date \_\_\_\_\_

## REVIEW OF SYSTEMS

Patient's Name \_\_\_\_\_ DOB \_\_\_\_\_

	Yes	No		Yes	No
<b>General</b>			<b>Lungs</b>		
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Marked weight gain/loss	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to heat/cold	<input type="checkbox"/>	<input type="checkbox"/>	Coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>
			Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
			Sputum	<input type="checkbox"/>	<input type="checkbox"/>
<b>HEENT</b>			<b>Heart</b>		
Decreased vision	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
Decreased hearing	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Irregular heart	<input type="checkbox"/>	<input type="checkbox"/>
Glasses/Glasses	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	Swelling in ankles	<input type="checkbox"/>	<input type="checkbox"/>
Loss of smell	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath at night or lying down	<input type="checkbox"/>	<input type="checkbox"/>
Nose bleed	<input type="checkbox"/>	<input type="checkbox"/>	How many pillows do you sleep on?	_____	
Dental problems	<input type="checkbox"/>	<input type="checkbox"/>			
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<b>GI</b>		
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting up blood	<input type="checkbox"/>	<input type="checkbox"/>
<b>Neck</b>			Black tarry stool	<input type="checkbox"/>	<input type="checkbox"/>
Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of neck	<input type="checkbox"/>	<input type="checkbox"/>	Peptic ulcer	<input type="checkbox"/>	<input type="checkbox"/>
<b>Breasts</b>			Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Lumps	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder disease	<input type="checkbox"/>	<input type="checkbox"/>
<b>CNS</b>			Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<b>GU</b>		
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Pain on urination	<input type="checkbox"/>	<input type="checkbox"/>
Fainting episodes	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty when you first try to urinate	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	How many times do you urinate at night?	_____	
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	How many times per day do you urinate?	_____	
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Control of urine when coughing	<input type="checkbox"/>	<input type="checkbox"/>
<b>GYN</b>			Vaginal/penile discharge	<input type="checkbox"/>	<input type="checkbox"/>
Last menstrual period	_____		Incomplete empty bladder	<input type="checkbox"/>	<input type="checkbox"/>
Last PAP smear	_____		Do you urinate more than before?	<input type="checkbox"/>	<input type="checkbox"/>
Age of first menstruation	_____		Do you urinate less than before?	<input type="checkbox"/>	<input type="checkbox"/>
Interval between periods	_____		Sex problems	<input type="checkbox"/>	<input type="checkbox"/>
Number of births	_____				
Number of pregnancies	_____				

Provider's Signature \_\_\_\_\_ Date \_\_\_\_\_

Susan Biegel M.D. Inc.  
1113 Alta Ave. Suite 220  
Upland, CA 91786  
Tel. (909) 985-1908 Fax (909) 985-6828

Dear Patient,

This is our office policy: if you do not keep your appointments, with the doctors or other providers, or call and give a 24-hour notice of cancellation, **you will be charged a \$50 fee per every missed appointment.**

Thank you for your courtesy.

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Signature

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Date

---

Print Name

---

DOB



# HIPAA NOTICE OF PRIVACY PRACTICES

Susan Biegel M.D.  
1113 Alta Ave. Ste. 220  
Upland, CA 91786  
Tel (909) 985-1908 Fax (909) 985-6828

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment of health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

## **Uses and Disclosure of Protected Health Information**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care for you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners: Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

# HIPAA NOTICE OF PRIVACY PRACTICES

Susan Biegel M.D.  
1113 Alta Ave. Ste. 220  
Upland, CA 91786  
Tel (909) 985-1908 Fax (909) 985-6828

## Your Rights

The following is a statement of your rights with respect to your protected health plan.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You have the right to use another Health Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You have the right to have your physician amend your protected health information. If we deny request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

## Complaints

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only an acknowledgment that you have received this Notice of our Privacy Practices.

_____ Signature	_____ Date
_____ Print Name	_____ DOB

## ADVANCED DIRECTIVES

Susan Biegel M.D.  
1113 Alta Ave. Ste. 220  
Upland, CA 91786  
Tel (909) 985-1908 Fax (909) 985-6828

This acknowledgment states that the physician, or one of his/her staff members, has provided me information concerning Advanced Directives.

1. I am age 18 or older. Yes No
  
2. I realize that I have the option of putting together Advanced Directives for my healthcare. My physician has provided me written information concerning these Advanced Directives. I understand that it is my responsibility to provide my doctor(s) with any documents that are required to carry out my Advanced Directives.
  
3. I am aware that the Advanced Directives may be any one of the following:
  - a. A Durable Power of Attorney for Health Care.
  - b. The Declaration in the A Natural Death Act – e.g. A Living Will
  - c. I may write down my wishes on a piece of paper so that my family may use the document in deciding my medical treatment, in the event I am unable to do so.

Signature	Date
Print Name	DOB

This document will become part of my medical record.

Susan Biegel M.D.  
1113 Alta Ave. Ste. 220  
Upland, CA 91786  
Tel (909) 985-1908 Fax (909) 985-6828

---

Signature \_\_\_\_\_ Date \_\_\_\_\_

---

Print Name \_\_\_\_\_ DOB \_\_\_\_\_

**Please let us know who we could  
thank for the referral!!!**

- Family: \_\_\_\_\_
- Friend: \_\_\_\_\_
- Physician: \_\_\_\_\_
- Insurance Roster: \_\_\_\_\_
- Yellow Pages: \_\_\_\_\_
- Other: (please specify) \_\_\_\_\_

Thank you for your support!!!

Dr. Susan Biegel and Staff

# AUTHORIZATION TO RELEASE HEALTH INFORMATION

\_\_\_\_\_

Print Name DOB

NOTICE

Susan Biegel M.D. and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep you health information confidential.

I authorize the doctors below to release health information to:

Susan Biegel M.D.  
1113 Alta Ave. Ste. 220  
Upland, CA 91786  
Tel (909) 985-1908  
Fax (909) 985-6828

\_\_\_\_\_

Signature (of Patient or Patient's Legal Representative) Date

Doctor #1 Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Doctor #2 Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Doctor #3 Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Witness \_\_\_\_\_  
(only if patient is unable to sign) Relationship to Patient

Interpreter \_\_\_\_\_  
Relationship to Patient

\*\*\*\*\*Unless otherwise revoked, this authorization expires in 1 year\*\*\*\*\*

Susan Biegel M.D. Inc.  
1113 Alta Ave. Suite 220  
Upland, CA 91786  
Tel. (909) 985-1908 Fax (909) 985-6828

Dear Patient,

This is our office policy: if a service is performed and your Insurance is not eligible for the period in which the service was rendered, **you are responsible for the payment of the service(s) that was rendered.**

Thank you for your courtesy.

---

Signature

---

Date

---

Print Name

---

DOB

Susan Biegel M.D.

## ADVANCED DIRECTIVES

Part 1: Choose your health care agent

- I want this person to help make my medical decisions.

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First Name		Last Name	
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Street Address	City	State	Zip Code
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Home Phone Number		Work Phone Number	
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- If the first person cannot do it, then I want this person to help make my medical decisions.

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First Name		Last Name	
------------	--	-----------	--

---

Street Address	City	State	Zip Code
----------------	------	-------	----------

---

Home Phone Number		Work Phone Number	
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- Put an X next to the sentence you agree with.
  - My health care agent can make decisions for me **now**.
  - My health care agent will make decisions for me **only** after I cannot make my own decisions.

Susan Biegel M.D.

Part 2: Make your own health care choices

**Write down your choices  
so those who care for you will not have to guess.**

- Think about what makes your life worth living.  
Put an X to **all** the statements with which you most agree.
  - My life is **only** worth living if I can:
    - o Talk to family or friends
    - o Wake up from a coma
    - o Feed, bathe, or take care of myself
    - o Be free from pain
    - o Live without being hooked up to a machine
    - o I am not sure
  - My life is always worth living no matter how sick I am.
  
- If I am dying, it is important for me to be:
  - at home
  - in the hospital
  - I am not sure
  
- Is religion or spirituality important to you?
  - Yes
  - No
  
- What should your doctors know about your religion or spirituality?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Susan Biegel M.D.

Part 2: Make your own health care choices

**Life support treatments are used to try to keep you alive. These can be CPR, a breathing machine, feeding tubes, dialysis, blood transfusions, or medicine.**

Put an X next to the sentences with which you most agree.  
Please read this whole page before making your choice.

- If I am so sick that I may die soon:
  - Try all life support treatments that my doctors think might help. If the treatments **do not work** and there is little hope of getting better, **I want to stay** on life support machines.
  - Try all life support treatments that my doctors think might help. If the treatments **do not work** and there is little hope of getting better, **I do not want to stay** on life support machines.
  - Try all life support treatments that my doctors think might help **but not** these treatments. Mark what you **do not** want.
    - CPR
    - Dialysis
    - Breathing Machine
    - Other Treatments \_\_\_\_\_
    - Feeding Tube
    - Blood Transfusion
    - Medicine
  - I **do not want any** life support treatments.
  - I want my **health care agent** to decide for me.
  - I am **not sure**.

Susan Biegel M.D.

Part 2: Make your own health care choices

**Your doctors may ask about organ donation and an autopsy after you die.  
Please tell us your wishes.**

Put an X next to the sentence with which you most agree.

- Donating (giving) your organs can help save lives.

I **want** to donate my organs.

Which organs do you want to donate?

Any organs

Only \_\_\_\_\_

I **do not want** to donate my organs.

I want my **health care agent** to decide for me.

I am **not sure**.

- An autopsy can be done after death to find out why someone died. It is done by surgery. It can take a few days.

I **want** an autopsy.

I **do not want** an autopsy.

I **want** an autopsy **if there are questions** about my health.

I want my **health care agent** to decide for me.

I am **not sure**.

- What should your doctors know about how you want your body to be treated after you die?

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Susan Biegel M.D.

### Sign the Form

- Before this form can be used, you must:
  - sign this form.
  - have two witnesses sign the form.

If you do not have witnesses, you need a notary public.  
A notary public's job is to make sure it is you signing the form.

- Sign your name and write the date.

Sign your name		Date	
Print your name		DOB	
Address	City	State	Zip Code

- Your witness must:
  - be over 18 years of age.
  - know you.
  - see you sign this form
- Your witness cannot:
  - be your health care agent, doctor, nurse or social worker.
  - benefit financially (get any money) after you die.
  - work at the place you live.
- Only one witness can be a family member.  
The second witness must be someone other than family.

Witnesses need to sign their names on the next page.

If you do not have witnesses, take this form to a notary public and have them sign.

Susan Biegel M.D.

**Have your witnesses sign their names  
and write the date.**

- Witness #1

---

Sign your name	Date
----------------	------

---

Print your name	DOB
-----------------	-----

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Address	City	State	Zip Code
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- Witness #2

---

Sign your name	Date
----------------	------

---

Print your name	DOB
-----------------	-----

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Address	City	State	Zip Code
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You are now done with this form.

Share this form with your doctors, nurses, social workers, friends and your family.

Talk to them about your choices.

Susan Biegel M.D.