New Patient Information
Atelier Health

A. IDENTIFYING INFORMATION **Today's Date** _____

Name _____ Age _____

Date of Birth _____ Cell Number _____

Sex O male O female Home Number _____

Social Security # _____ Email _____

Driver's License # _____ Address _____

Referred by _____ City _____ State ____ ZIP _____

Marital Status O single O married O divorced O widowed

B. EMERGENCY CONTACT INFORMATION

Name _____ Relationship to Patient _____

Phone Number _____ Address _____

Email _____ City _____ State ____ ZIP _____

C. INSURANCE INFORMATION

Primary Insurance _____ Name of Insured _____

ID # _____ DOB of Insured _____

Group # _____ Relationship to Patient _____

Secondary Insurance _____ Name of Insured _____

ID # _____ DOB of Insured _____

Group # _____ Relationship to Patient _____

I hereby authorize payment of any medical and surgical insurance benefits to Ram Dandillaya, MD. I understand I am financially responsible for any charges whether or not paid by said insurance. If copayment and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Ram Dandillaya, MD. I authorize Ram Dandillaya, MD to release any medical information required to process any claims for reimbursements on my behalf. A copy of this authorization may be used in place of the original.

_____ _____ _____

Name (Print) **Signature** **Date**

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D. MEDICAL HISTORY

	Date of Diagnosis	Other Medical Conditions	Date of Diagnosis
O High blood pressure	_____	O _____	_____
O High cholesterol	_____	O _____	_____
O Diabetes	_____	O _____	_____
O Atrial fibrillation	_____	O _____	_____
O Congestive heart failure	_____	O _____	_____
O Coronary artery disease	_____	O _____	_____
O Pacemaker	_____	O _____	_____

E. SURGICAL HISTORY

Procedure	Date	Procedure	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

F. SOCIAL HISTORY

Number of children: _____ **Occupation:** _____

Tobacco Use (choose one): O Current Smoker: Number of cigarettes and/or cigars per day _____
Number of years smoking _____

O Former Smoker: Number of cigarettes and/or cigars per day _____
Number of years smoking _____ Quit Date_____

O Lifelong Nonsmoker

Alcohol Use: Number of drinks per week: _____ **IV / Illicit Drug Use:** O No O Yes: _____

G. FAMILY HISTORY

	Age	Alive / Deceased	Medical Conditions / Cause of Death (if applicable)
Mother	_____	_____	_____
Father	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

H. HEALTH MAINTENANCE

Have you had any of the following? When was your most recent?

O Coronary Calcium Scan _____ O Colonoscopy _____ O Mammogram _____ O Bone Density _____

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I. REASON FOR VISIT

O Establish Care with a new Primary Care Physician
O Pre-Operative Evaluation
O Cardiac Evaluation
O Other: _____

Any specific concerns today? _____

J. REVIEW OF SYSTEMS

Have you recently had any of the following?

O Chest Pain
O Palpitations
O Shortness of Breath
O Dizziness
O Abdominal Pain
O Back Pain
O Leg / Ankle Swelling
O Heartburn
O Anxiety
O Depression
O Loss of Consciousness
O Headaches
O Fatigue
O Other: _____
O Viral Symptoms
O Cough
O Asthma
O Arthritis
O Numbness / Tingling
O Weight loss / gain (>10 lbs)

K. ALLERGIES

Name of drug, food, material, or other	Reaction

L. MEDICATIONS

Name	Dose	Frequency

Preferred Pharmacy: Address _____ City _____

Phone Number _____ State _____ ZIP _____

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.

Ram Dandillaya, MD (a professional corporation, a.k.a. "the practice") uses health information about you for treatment, to obtain payment for treatment, for administration purposes, and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of Ram Dandillaya, MD. This disclosure is mandated by the HIPAA law.

How the practice may use or disclose your health Information:

Treatment: We may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider, such as a physician, nurse, or other person providing health services to you, will record information in your record that is related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health core providers will also record actions taken by them in the course of your treatment and note how you respond to the actions.

Payment: We may use and disclose your health information to others for purposes of receiving payment for treatment and services. For example, a bill may be sent to you or a third-party payer, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

Health Care Operations: We may disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and others to:

- Evaluate the performance of our staff;
- Assess the quality of care and outcomes in your case and similar cases;
- Learn how to improve our facilities and services: and
- Determine how to continually improve the quality and effectiveness of the health care we provide.

Appointments: Ram Dandillaya, MD may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Required by Law: Ram Dandillaya, MD may use and disclose information about you as required by law. For example, Ram Dandillaya, MD may disclose information for the following purposes

- For judicial and administrative proceedings pursuant to legal authority;
- To report information related to victims of abuse, neglect or domestic violence; and
- To assist law enforcement officials in their law enforcement duties.

Public Health: Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to protect or control disease, injury, or disability, or for other health oversight activities.

Decedents: Health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Organ/tissue donation: Your health information may be used or disclosed for cadaveric organ, eye or tissue donation purposes.

Research: Ram Dandillaya, MD may use your health information for research purposes when an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved the research.

Health and safety: Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Government Functions: Specialized government functions such as protection of public officials or reporting to various branches of the armed services that may require use or disclosure of your health information.

Workers Compensation: Your health information may be used or disclosed in order to comply with laws and regulations related to Workers Compensation.

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Atelier Health

Your Health Information Rights

You have the right to:

- Request a restriction on certain uses and disclosures of your information as provided by 45 C.F.R. 164.522: Ram Dandillaya. MD is not required to agree to a requested restriction;
- Obtain a paper copy of the notice of information practices upon request;
- Inspect and obtain a copy of your health record as provided for In 45 C.F.R 164.524;
- Amend your health record as provided in 45 C.F.R 164.526;
- Request in writing that communications of your health information by alternative means or at alternative locations;
- Revoke in writing that communications of your health information by alternative means or at alternative locations;
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken; and
- Receive an accounting of disclosures made of your health information as provided by 45 C.F.R 164.526

Complaints

You may complain to Ram Dandillaya, MD and to the US Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Obligations to Ram Dandillaya, MD

Ram Dandillaya, MD is required to:

- Maintain the privacy of protected health information;
- Provide you with this notice of its legal duties and privacy practices with respect to your health information;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction on how your information is used or disclosed;
- Accommodate reasonable requests you may make to communicate health information by alternative means. or at alternative locations; and
- Obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

Contact Information

If you have any questions or complaints, please contact:

Ram Dandillaya, MD
150 N Robertson Blvd, Suite 150
Beverly Hills, CA 90211
(310) 854-4995

Acknowledgment of Receipt of Notice of Privacy Practices

By signing this document, I acknowledge I have read and received a copy of Notice of Privacy Practices.

Name (Print)	**Signature**	**Date**

New Patient Information
Atelier Health

Missed Appointment and Cancellation Policy

Physicians at Atelier Health see patients by appointment only. We are sensitive to the busy schedules of our patients and strive to make every effort to provide prompt medical care and services. We will make every effort to maintain appointment times and commitments, and request you extend the same courtesy to us by adhering to the following policies:

Missed Appointments ("No Show"):

Any cancellation must be made **24 hours in advance** of your scheduled appointment by calling the office. Failure to cancel an appointment that you do not attend will be considered a missed appointment. As missed appointments affect our ability to provide timely attention to our patients, there will be a **$75 fee** for every missed appointment.

Late Arrivals:

If you are running late to your appointment, please call our office to inform us. If you are more than **10 minutes late, we may ask you to reschedule** in order to avoid delays in appointments and extensive waiting times. If you are continually arriving late to your scheduled appointments, a **$75 late fee** will be charged on the **third occurrence.**

* All missed appointment and late fees need to be paid before your next scheduled appointment *

Acknowledgment of Receipt of Missed Appointment and Cancellation Policy

By signing this document, I acknowledge I have read and received a copy of Missed Appointment and Cancellation Policy.

_____	_____	_____
Name (Print)	**Signature**	**Date**

With the above-stated policy, we offer the option of credit card payment and keeping credit card information on file. If you choose to do so, please provide the information below:

Name on card: _____ Card Type: Visa MasterCard AmEx

Card Number: _____ Expiration Date: _____ CVV: _____

I authorize Atelier Health to charge my credit card on file accordingly for any missed or late appointments, as described above.

_____	_____	_____
Name (Print)	**Signature**	**Date**

Notice to Patients About Open Payments Database

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov/

Patient Acknowledgement:

Print Name: _____

Signature: _____ *Date:* _____