

Newport Medical and Wellness Center

Welcome to our practice!

Office Hours

8 am – 5pm Monday through Friday; Closed 12:00pm to 2pm for lunch; 9am – 1pm Saturday; closed all major holidays

After Office Hours

For urgent medical issues after regular office hours that cannot wait until next business day, please call our office number to be connected to the on-call doctor's paging service. For all other issues, please call us during our regular office hours.

Same Day/ Urgent Appointments

We understand that sometimes medical problems come up and you would like to be evaluated sooner than the next available appointment. Please let us know and we will try to accommodate you the same or following day.

Emergencies

Call 9-1-1 for medical emergencies

Medication Refills

We do not want you to run out of your medications. We recommend that you notify the pharmacist to send us a "refill request" when you are picking up your last refill. If you prefer to call us, please call us during our regular office hours and allow **3-4 business days** for us to refill your medications.

Forms

Please make an appointment if you have any forms that will require our doctors to fill out. Most forms require an evaluation and possible laboratory testing to complete. If forms are walked in without an appointment the charge will be \$35.00, DMV physicals with required forms at time of the visit will be \$125.00, and Sports/School physicals will require a waiver signed if no insurance coverage the charge will be \$75.00

Medical Care

We are concerned about your health. In order for us to provide the best possible quality care for you, we will need your cooperation in keeping your scheduled appointments, making follow up appointments, scheduling annual physical exams, and completing tests ordered for you.

Canceling Appointments

As of January 2009, we will require 24 hours notice or 1 business day's notice, whichever is greater to cancel an appointment. Failure to provide this notice will result in a service charge of **\$50.00**, which will **NOT** be covered by your insurance company. We ask that one be respectful of our time and of other patients who are trying to get an appointment by adhering to this cancelation policy.

Other Physicians or Health Care Specialist

If you are seeking healthcare from other physicians in the community, we would like you to ask their office to send us a copy of their notes and studies.

Communication

We believe in having good communication between our staff and our patients. We encourage you to express any questions or concerns to us so we may better serve you.

Co pays/ New Patients/ Returned checks

Co pays are due at time of service. There is a \$15.00 service charge for any unpaid co pays. We will only accept cash credit/debit cards for New Patient/first time visits. For any returned checks from established patients, there will be a \$25.00 service charge.

****We utilize the California Department of Justice Bureau of Narcotic Enforcement real-time Prescription Drug Monitoring Program to identify prescription drug abuse. Our doctors will not prescribe controlled substances if a potential problem exists. You will be responsible for standard office visit charges for the evaluation.****

PATIENT INFORMATION

LAST NAME		FIRST NAME		M.I.	NAME YOU PREFER TO BE CALLED		SEX
ADDRESS			APT #	CITY		STATE	ZIP
SOCIAL SECURITY #		BIRTHDATE		HOME TELEPHONE #		CELL PHONE #	
WORK TELEPHONE #				E-MAIL ADDRESS			
EMPLOYER		EMPLOYER ADDRESS			POSITION/ TITLE		
HOW DID YOU HEAR ABOUT US?							
EMERGENCY CONTACT NAME & TELEPHONE NUMBERS							
WHO WAS YOUR PREVIOUS PRIMARY PHYSICIAN?				TELEPHONE #			
PHYSICIAN ADDRESS							

GUARANTOR/ POLICY HOLDER INFORMATION

LAST		FIRST NAME		M.I.	RELATIONSHIP TO PATIENT		
					SPOUSE PARENT OTHER:		
ADDRESS IF DIFFERENT FROM PATIENT							
BIRTH DATE			SOCIAL SECURITY #				
GUARANTOR/ POLICY HOLDER'S EMPLOYER		EMPLOYERS ADDRESS			CITY	STATE	ZIP

INSURANCE INFORMATION

1.PRIMARY INSURANCE PLAN		GROUP NUMBER			POLICY NUMBER		
TYPE OF PLAN OR COVERAGE							
HMO	PPO	EPO	MEDI-CAL	MEDICARE	MEDICARE SUPPLEMENT	CASH	OTHER
POLICY OWNERS NAME (GUARANTOR)				IPA		PRIMARY CARE PROVIDER	
2.SECONDARY INSURANCE PLAN		GROUP NUMBER			POLICY NUMBER		
TYPE OF PLAN OR COVERAGE							
HMO	PPO	EPO	MEDI-CAL	MEDICARE	MEDICARE SUPPLEMENT	CASH	OTHER
POLICY OWNERS NAME (GUARANTOR)				IPA		PRIMARY CARE PROVIDER	

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. Once the insurance company is billed we allow 60 days for the balance to be paid by your insurance carrier. If the insurance carrier does not remit payment in 60 days, the balance will be due in full from you. If any payment is subsequently made by your insurance carrier in excess of the balance, we will gladly refund the overpayment to you within 30 days, providing that you do not have any outstanding accounts with our office. It is also customary to pay for professional services when rendered unless prior arrangements are made. I request that payment of authorized Medicare/other insurance company benefits be made on my behalf to Newport Medical and Wellness. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the social security administration and healthcare financing administration or its intermediaries or carriers, any information needed for this or a related Medicare claim or other insurance claim. I permit a copy of this authorization to be used in place of the original and request that payment of medical insurance benefits be made payable to Newport Medical and Wellness. I understand that it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment.(section 1128b of the social security act and 31 u.s.c 3801-3812 provides penalties for withholding this information.) There is a \$20.00 charge for all returned checks. All unpaid balances are subject to 1.5% interest or minimum \$6.00 service charge after 90 days. If your account must be forwarded to a collection service and/or an attorney because of nonpayment, you will be responsible for all collection fees and/or attorney fees charged by these services.

PATIENTS SIGNATURE _____ GUARANTORS SIGNATURE _____ DATE _____

HEALTH HISTORY FORM

Patient Name: _____

Date of Birth: _____

Personal Medical History: Have you ever had (please circle all answers Yes or No)

High Blood Pressure	No	Yes	Anxiety	No	Yes	Pneumonia	No	Yes
Heart Disease	No	Yes	Depression	No	Yes	Meningitis	No	Yes
Heart Murmur	No	Yes	Epilepsy	No	Yes	Gonorrhea	No	Yes
High Cholesterol	No	Yes	Osteoporosis	No	Yes	Chlamydia	No	Yes
Diabetes	No	Yes	Thyroid Disease	No	Yes	Syphilis	No	Yes
Anemia	No	Yes	Asthma	No	Yes	Genital Herpes	No	Yes
Stomach pain or Reflux	No	Yes	Hives or Eczema	No	Yes	Genital Warts	No	Yes
Arthritis or Rheumatism	No	Yes	Migraines	No	Yes	Tuberculosis	No	Yes
Kidney disease	No	Yes	Gallbladder Disease	No	Yes	AIDS/HIV	No	Yes
Neuritis or Neuralgia	No	Yes	Colitis or other Bowel Disease	No	Yes	Race/Ethnicity: _____		
Bone or Joint disease	No	Yes	Jaundice or Liver Disease	No	Yes			
Sciatica, Back pain	No	Yes	Cancer *	No	Yes	* Type of Cancer: _____		

If "yes" to any of the above, please describe further: _____

If you have, or have had, any symptoms in the following areas to a significant degree, please briefly explain.

Skin:	Back/Joints:	Recent Changes in the following:
Head/Neck:	Intestinal:	Weight:
Ears/Nose/Throat:	Bladder:	Energy level:
Lungs:	Menstruation:	Mood:
Chest/Heart:	Circulation:	Other pain or discomfort:

Other Medical Problems & Surgeries:

List All Current Medication and Dosages: (include non-prescription)

Allergies to medications or food:

Describe the allergic reaction:

Do you drink alcohol? No Yes
Do you or have you ever smoked? No Yes
Do you use drugs? No Yes

Number of drinks _____ per week Quit date: _____
How many cigarettes per day: _____ How many years: _____
Quit date: _____
What kind: _____ How many years: _____

Are you currently(circle one): Married Single Divorced Widowed
How many children do you have? _____ Ages: _____

Occupation: _____ Employer: _____ Highest level of education: _____

Please list the last date you had any of the following:

Pap Smear _____ Mammogram _____ Prostate Exam _____ Colonoscopy _____

Family Medical History: *example: cancer (type), diabetes, heart disease, mental illness, stroke, seizure, etc.*

Father: _____ Paternal grandfather: _____
Mother: _____ Paternal grandmother: _____
Siblings: _____ Maternal grandfather: _____
_____ Maternal grandmother: _____

PATIENT RESPONSIBILITIES

As a partner in your healthcare, you have the following responsibilities:

1. I will provide accurate health information to your doctor and update us with any health changes.
2. I will schedule routine physical exams and other health maintenance exams recommended to me by my doctor (pap smear, mammogram, bone density, colonoscopy, routine blood tests, immunizations, etc.). I put myself at risk for not detecting other medical diseases if I only see my doctor for immediate problems. I will make appointments with my doctor to discuss routine health screenings.
3. I will follow treatment plans recommended to me by my physician, including completing testing, making an appointment with a specialist, and taking my medications. I will be sure to clearly comprehend any treatment plan and ask questions when I do not understand. I understand that *not* following my treatment plans may put my health at risk.
4. I will keep my appointments and reschedule any missed appointments. I understand that my doctor schedules these appointments to follow up on my response to treatment and to monitor my medical conditions. During these appointments my physician may order tests, refer me to a specialist, change my medications, and diagnose a medical problem. If I do not follow up, I may put my health at risk and may have medical conditions go undetected.
5. I understand that the goal of the office is to provide me with test results in a timely fashion. If I do not hear from the office, I will call the office for test results. I understand that not hearing from the office about a particular test does not necessarily mean that the test result is normal.
6. I will inform my doctor if my medical condition changes, does not improve, or worsens. This will allow my doctor to re-evaluate my condition and make changes in treatment. If I do not inform my doctor, I may put my health at risk.
7. I will take charge of my health and make positive choices for my health including not smoking, not using illegal drugs, eating a healthy diet, and getting appropriate exercises.
8. I will treat all providers and office staff respectfully and courteously.
9. I will fulfill my financial obligations for care provided to me in a timely manner.
10. I will keep my scheduled appointments and give adequate notice of rescheduling or cancellation.
11. I will take responsibility to understand my Health Plan and be aware of my benefits, deductibles, and Health Plan limitations. I will ask my Health Plan if I have any questions regarding my health coverage.
12. If you need information or inquiring about Advance Directives (Durable Power of Attorney for Health Care, Natural Death Act Declaration or Living Will,) please call the Member Services Department of your Health Plan.

I have been informed of my responsibilities and I understand them fully.

Print Name: _____ Date: _____

Signature: _____

NO SHOW POLICY

If there is need to reschedule or cancel your appointment, we ask that you notify us at least 24 hours in advance. We have reserved this appointment time for you on the doctor's schedule in order to handle your medical needs in an efficient and timely manner. If notice of rescheduling or cancellation is within 24 hours of the appointment reserved for you, there will be a \$50 charge. Accumulation of 3 missed appointments, may result in a notice of non-compliance and denial of rescheduling.

I have read and understand this policy and agree to its terms.

Patient Signature & Date

COSMETIC INTEREST QUESTIONNAIRE

Patient Name: _____

Date: _____

General appearance or products of interest to you (please check all that apply).

<input type="checkbox"/> Eyelash length, fullness, thickness, or darkness <input type="checkbox"/> Skin care products <input type="checkbox"/> BOTOX [®] Cosmetic <input type="checkbox"/> Facial fine lines <input type="checkbox"/> Facial wrinkles <input type="checkbox"/> Facial folds <input type="checkbox"/> Thin lips <input type="checkbox"/> Skin care advice	<input type="checkbox"/> Facial veins <input type="checkbox"/> Facial redness <input type="checkbox"/> Liver spots/age spots <input type="checkbox"/> Birthmark <input type="checkbox"/> Tattoo removal <input type="checkbox"/> Drooping eyelids <input type="checkbox"/> Nose <input type="checkbox"/> Facial fullness <input type="checkbox"/> Blotchy skin	<input type="checkbox"/> Neck <input type="checkbox"/> Breast size <input type="checkbox"/> Abdominal area <input type="checkbox"/> Hips <input type="checkbox"/> Legs <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
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Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

<i>Younger Than</i>		<i>True Age</i>		<i>Older Than</i>
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

<i>Not Concerned</i>		<i>Somewhat Concerned</i>		<i>Very Concerned</i>
1	2	3	4	5

How did you hear about us?

<input type="checkbox"/> My physician	Full name: _____
<input type="checkbox"/> My insurance company provider	Name: _____
<input type="checkbox"/> The yellow pages	Specify Ad: _____
<input type="checkbox"/> A friend or family member	Name: _____
<input type="checkbox"/> Internet	
<input type="checkbox"/> The Physician/Practice website	
<input type="checkbox"/> Seminar	Date/location: _____
<input type="checkbox"/> Other	

Are you interested in meeting with one of our professional cosmetic consultants in order to create a Personal Treatment Plan designed to meet your cosmetic needs?

YES No thanks

<input type="checkbox"/> Approval to contact you.	Best phone number to reach you: _____
<input type="checkbox"/> Approval to send you information on products and services (including special offers)	Email address: _____

Patient Signature: _____

Date: _____

For Office Use Only

Physician (provider) name: _____		
<i>Follow-up</i>	<i>Date</i>	<i>Completed by (name)</i>
<input type="checkbox"/> Initial Inquiry/Information Mailed		
<input type="checkbox"/> Follow-up call		
<input type="checkbox"/> Seminar participation		
<input type="checkbox"/> Free consultation		
<input type="checkbox"/> Procedure scheduled		
<input type="checkbox"/> Procedure completed		

Comments: _____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for **John LaLonde, D.O. /Jose Mayorga, M.D.** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

(The Notice of Privacy Practices provided by **John LaLonde, D.O. /Jose Mayorga, M.D.** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent.

John LaLonde, D.O. /Jose Mayorga, M.D. reserves the right to revise its Notice of Privacy Practices at any time.

A revised Notice of Privacy Practices may be obtained by forwarding a written request to **John LaLonde, D.O. /Jose Mayorga, M.D. 2216 Newport Blvd. Costa Mesa, CA 92627.**

With this consent **John LaLonde, D.O. /Jose Mayorga, M.D.** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **John LaLonde, D.O. /Jose Mayorga, M.D.** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, and any items pertaining to my clinical care, including laboratory test results, among others.

With this consent, **John LaLonde, D.O. /Jose Mayorga, M.D.** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, and any items pertaining to my clinical care, including laboratory test results, among others.

I have the right to request that **John LaLonde, D.O. /Jose Mayorga, M.D.** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **John LaLonde, D.O. /Jose Mayorga, M.D.** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **John LaLonde, D.O. /Jose Mayorga, M.D.** may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Date

Relationship to Patient

Print Patient's Name

Print Name of Legal Guardian, if applicable