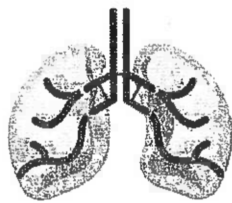


WEST COAST LUNG
RUTLAND MEDICAL GROUP

Cedric "Jamie" Rutland, M.D.
Newport Superior Medical Plaza
1501 Superior Ave Ste 111
Newport Beach, CA 92663

Patient Information

Last Name: ______________________ First Name: ___________________________ MI:______

Also Known As/Maiden Name: _________________________ SSN:_______________________

D.O.B: ___/___/____ Sex: ____ Marital Status: Single___ Married___ Divorced___ Widowed___

Address: ____________________________ City: ___________________ State/Zip:__________

Home Phone: (__) _____-______ Cell Phone: (__) _____-______

Email Address: www.______________@________.com

Pharmacy: ____________________________ Fax: (__) _____-______

Employment Status: Employed___ Not Employed___ Retired___ Student___

Employer: __________________ Occupation:___________________ Phone: (__) _____-______

Emergency Contact Name: _______________________________ Relationship: ______________

Address: ____________________________ City: ___________________ State/Zip:__________

Home Phone: (__) _____-______ Cell Phone: (__) _____-______

Referred By: _________________________ Relationship:______________________________

If referred by Physician please provide the following:

Phone Number: (__) _____-______ Fax Phone: (__) _____-______

Address: ____________________________ City: ___________________ State/Zip:__________

Spouse, Parent, Legal Guardian or Responsible Party (if Different from Patient)

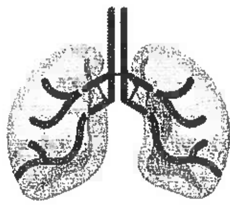
Name:__________________________ Relationship to Patient:_____________________

Date of Birth: _____________________

Address: ____________________________ City: ___________________ State/Zip: __________

Home Phone: (__) _____-______ Cell Phone: (__) _____-______

Work Phone: (__) _____-_______



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Patient Phone Message Consent

It is our policy to notify you of test results ordered by this office and to call you to confirm appointments. This is to acknowledge that you authorize us to:

- Leave a detailed message on voice mail/machine/cell Yes: _______No:________(initial yes or no)
- Leave a detailed message with individual answering phone Yes: _______No:________ (initial yes or no)
- If you answered yes to the following please indicate which phone # you would like our staff to use

  (___) _____-______

Primary Insurance Name: ________________________________

Circle if applies: Medicare PPO POS EPO

ID/Subscriber #:________________________ Group: ________________________________

Phone Number: (___) _____-______Cell Phone: (___) _____-______

Secondary Insurance/ Supplemental Name: ____

Circle if applies: Medicare PPO POS EPO

ID/Subscriber #:________________________ Group: ________________________________

Phone Number: (___) _____-______Cell Phone: (___) _____-______

It is the responsibility of the patient to know their financial obligations under their insurance plans, such as co-pays, deductibles, co-insurance, referral fees, etc. Your insurance card must be provided at the first visit. If not, we will consider it as a self-pay/cash visit. If you change your insurance, it is **your** responsibility to inform us of the change. If we are unable to bill your insurance company for the visit due to incorrect information, then it will be considered as self-pay / cash visit. **West Coast Lung** does not know the details of you individual plan and is not authorized to make guarantees regarding coverage.

Sign:______________________________ **Date:**________________________________

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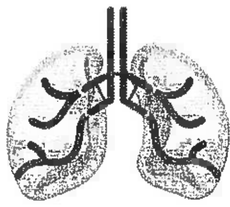

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Sharing of Medical Information

I give the physician and office staff of **West Coast Lung** permission to discuss my medical condition with the following individuals:

Name: ______________________ Relationship: __________________ Phone Number: (___) _____-______

Name: ______________________ Relationship: __________________ Phone Number: (___) _____-______

Name: ______________________ Relationship: __________________ Phone Number: (___) _____-______

Important Information about Lab Test

It is you responsibility to check with your insurance to see if they require you to use a specific lab and if so, which lab. Please notify us on the day of your appointment if we need to send your lab work or pap smears to another lab as required by your insurance. If you do not specify, your labs and pap will be sent to the labs listed below.

PPO and Medicare Ins – **PML, Labcorp, and Quest**

(Note: Aetna, HealthNet and Cigna MUST go to Quest)

Sign:______________________________ **Date:**______________________________

Authorization for Treatment and Assignment of Benefits

I hereby allow **West Coast Lung** to perform such medical services, which in their medical judgment are necessary for the welfare of the patient identified above. I hereby authorize **West Coast Lung** to furnish information to insurance carries concerning this illness/or injury. I hereby irrevocably assign all benefits, including major medical benefits for medical services rendered to be paid directly to the doctor in accordance with California insurance Code Section 10133. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that ultimately, I am financially responsible for all charges whether or not paid by insurance. I also understand that it is my responsibility to advise **West Coast Lung** of any and all changes in my personal and /or insurance information.

Sign:______________________________ **Date:**______________________________

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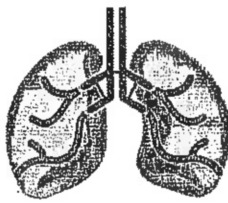

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Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand your "Notice of Privacy Practices" containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its " Notice of Privacy Practices" from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the "Notice of Privacy Practices."

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions but if you do not agree then you are bound to abide by such restrictions.

Patient Name ______________________________

Patient Representative ______________________________

Signature ______________________________

Date ______________________________

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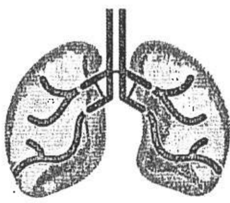

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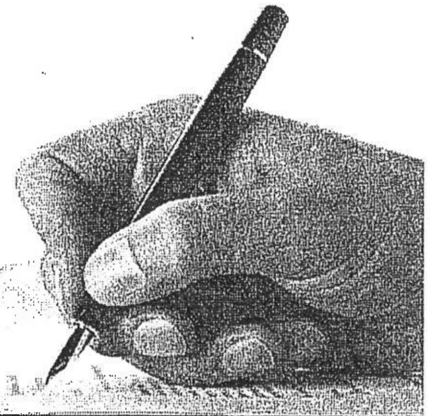
Advance Directives: What You Need to Know

What Is An Advance Directive?

- An Advance Directive is a document that states in writing your wishes about what type of care you would want or do not want, in case you get hurt, sick or become unable to make medical decisions for yourself.
- On the form, you may choose an adult relative, spouse, partner or friend as your "agent" to make these decisions when the time comes.
- You must sign your name and write the date on the form.



Where Do I Begin?

- You can write or fill out your own advance directive if you are 18 years or older, and are able to make your own decisions.
- You do not need a lawyer to fill out the document, but it must be signed by a notary public or by 2 witnesses. Your "agent" cannot be one of the witnesses.

Choose A Person You Trust.

- After you choose this person, talk to them in detail about what you want. Make sure this person knows your wishes and are willing to make them for you.
- Talk with your doctor and "agent" about what you want and give them both a copy.
- Your doctor may ask you to sign a form that states you have talked to them about this document.

Can I Change My Mind?

- You may change or cancel your advance directive at any time, as long as you are aware of how the choices impact your health care. Being aware means you can still think and voice your wishes in a clear manner. You can also change your "agent."
- Make sure that your doctor and your "agent" know about any changes.

Why Sign One Now When I'm Healthy?

- The best time to sign an advance directive is when you are healthy, and are able to think and speak for yourself. Having a plan in place will ensure that your wishes are followed.

Where Can I Get The Advance Directive Document?

- Most hospital emergency rooms and the Orange County Office on Aging have these forms. Call **1-800-510-2020** for more information. You do not need to use a form. You can also write your wishes down on paper and have this document signed instead.
- Contact Caring Connections at **www.caringinfo.org**.

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