Zand
Medical Partners

Patient Information

Name: _____ DOB: _____
Social Security Number: _____ Sex: M / F
Address: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Fax: _____
Email Address: _____
Marital Status: Single / Married / Divorced / Widowed / _____

Insurance Information

Primary Insurance: _____
Subscriber Name: _____ DOB: _____
Subscriber ID: _____ Group ID: _____

Do you have secondary insurance? Yes ☐ No (Skip this section) ☐

Secondary Insurance: _____
Subscriber Name: _____ DOB: _____
Subscriber ID: _____ Group ID: _____

Emergency Contact

Emergency Contact Name: _____
Home Phone: _____ Cell Phone: _____
Relationship to Patient: _____

Pharmacy Information

Pharmacy Name: _____
Work Phone: _____ Fax: _____
Address: _____

Rx History Consent: I hereby authorize Zand Medical Partners to obtain my previous prescription and medication history through external sources. _____ (initials)

The above information is complete and correct. I hereby authorize release of information necessary to file a claim with my insurance company. I assign benefits otherwise payable to me to Zand Medical Partners. I understand that I am financially responsible for charges for medical services rendered regardless of insurance coverage. I also understand that I am responsible for any office visit copayment due at time of service and/or deductibles that may apply. If this account is assigned to an attorney for collection and/or suit, a copy of the signature is valid as the original.

Print Name: _____

Signature: _____ Date: _____

Zand
Medical Partners

ZAND MEDICAL PARTNERS SCHEDULING POLICY

We value our patients' health and ask that you respect our office scheduling policies. For the courtesy of the staff, physicians, and all patients, we ask that you understand and agree to these terms and conditions.

Please be advised that starting October 1, 2022, there will be a charge of $45 for any same-day no shows or cancellations.

Starting February 1, 2026, CalOptima patients will be terminated from our practice following three no-show appointments.

It is very important that you call within 24 hours in advance to cancel or reschedule your appointment. When you do not show up for a scheduled appointment, it creates an unused appointment slot that could have been used for another patient.

If you have any questions please notify our office managers.
Office : (714) 285 - 2311

Thank you.

Print Name	Date of Birth
Patient Signature	Date

Zand
Medical Partners

PATIENT CONSENT FORM

The Department of Health and Human Services has established a “Privacy Rule” to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients’ consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations. As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest. We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent. You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: _____ Date: _____

Signature: _____

COMPLIANCE ASSURANCE NOTIFICATION FOR YOUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience and aggravation, and costing them money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the “Privacy Rule.” We strive to achieve the very highest standards of ethics and integrity in performing services for our patients. It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI. We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Zand
Medical Partners

NOTICE OF PRIVACY PRACTICE

HIPAA (Health Insurance Portability and Accountability Act) regulations require us to provide to you, the patient or personal representative, a copy of our Notice of Privacy Practice and for you to sign an **acknowledgement** receipt of this brochure.

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

You are authorizing Zand Medical Partners to share your health information with:
(Please list names of person and/or facility)

Name: _____

Relationship to Patient: _____

Name: _____

Relationship to Patient: _____

HEALOW

Zand Medical Partners offers patients the convenience of communicating via text message, email, and telephone. You can confirm and check-in to your appointments through these methods. We are also offering easy access to patient medical records, through the app Healow. These methods may be used for appointment reminders, general queries, or, with consent, sharing health information.

Signature: _____ Date: _____

Zand
Medical Partners

Privacy Officer Dalia Jaafar (714) 285-2311

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Patient Name: _____ **Date of Birth:** _____

Signature: _____ **Date:** _____

If not signed by the patient, please indicate relationship:

Name: _____

Relationship to Patient: _____

Phone Number: _____

Por la presente reconozco que recibí una copia del Aviso de esta práctica médica de prácticas de privacidad. Además, reconozco que una copia del aviso actual será en la zona de recepción, y que una copia de la Notificación de Prácticas de Privacidad modificado estará disponible en cada cita.

Nombre del paciente: _____ **Fecha de nacimiento:** _____

Firma: _____ **Fecha:** _____

Si no está firmada por el paciente, por favor indique la relación:

Nombre: _____

Relación con el paciente: _____

Teléfono: _____

Zand
Medical Partners

CONSENT TO USE TELEMEDICINE

WHAT IS TELEMEDICINE?

Telemedicine (also sometimes called telehealth) services are a way to deliver healthcare services locally to a patient when the healthcare provider is located at a distant site. Telemedicine is generally defined as the use of electronic information and communications technology to exchange medical information from one site to another site to provide medical or surgical treatment to a patient and/or to participate in the medical diagnosis of, or medical opinion or medical advice to, a patient.

When a healthcare provider believes a patient may benefit from the use of telemedicine services, telemedicine can maintain a continuity of care with the provider and facilitate patient self-management and caregiver support of the patient. Telemedicine services often provide a broader access to medical care, eliminate transportation concerns, and increase comfort and familiarity for patients and their families when located in their own homes or other local environments.

However, telemedicine uses new communications technology for which there is little research supporting its effectiveness. For example, telemedicine services may not be as complete as in-person healthcare services because the healthcare provider will not always be able to observe subtle non-verbal communications such as a patient's posture, facial expression, gestures, and tone of voice.

Telemedicine may transfer medical information through the use of interactive, real-time audio/visual technology (for example, video conferencing) or electronic data interchange (for example, computer-to-computer exchanges), or it may transfer medical information through the use of store-and-forward technology (for example, emails). While precautions are taken to secure the confidentiality of telemedicine services, the electronic transmission of medical information can be incomplete, lost or otherwise disrupted by technical failures. Additionally, despite such measures, the transmission and storage of medical information can be accessed by unauthorized persons, causing a breach of the patient's privacy.

By signing this consent, I understand and agree:

1. My doctor is located in and licensed by the State of California. My doctor may not be able to prescribe medications for me and/or may not be able to assist me in an emergency situation when I am located in any other state or country. If I require medication, I may contact my doctor. If I require emergency care, I may call 911 or proceed to the nearest hospital emergency room for help.

Zand
Medical Partners

2. I submit to the exclusive jurisdiction of the California state superior courts and agree that any claim, lawsuit, or other legal proceeding arising out of or relating to the telemedicine services provided by my doctor and my doctor's staff will be brought solely and exclusively in California state superior courts. I also agree that the interpretation of this consent will be exclusively governed by and construed in accordance with the laws of California.
3. My doctor believes that telemedicine services are appropriate for my medical condition and that I would benefit from its use despite its risks and limitations. While I may expect anticipated benefits from the use of telemedicine, no specific results can be guaranteed or assured.
4. If my doctor believes at any time that another form of services (for example, a traditional in-person consultation) would be appropriate, my doctor may discontinue telemedicine services and schedule an in-person consultation with my doctor or refer me to a healthcare provider in my area who can provide such services.
5. I have the right to withdraw consent to the use of telemedicine services at any time and receive in-person healthcare services with my doctor.
6. I received an explanation of how the electronic communications technology will be used for the telemedicine services. I am comfortable with using electronic communications technology to communicate with my doctor and understand there are limitations to the technology which may require an in-person consultation.
7. The laws that protect privacy and the confidentiality of my medical information also apply to telemedicine. The medical information that is transmitted electronically by my doctor to me will be encrypted during transmission and will be stored only by my doctor or a service provider selected by my doctor. I understand the dissemination of any personally-identifiable images or information from the telemedicine communication to researchers or other healthcare providers will not occur except as required by federal or California state law.
8. I understand it is my responsibility to encrypt medical information I transmit electronically to my doctor and my failure to use technical safeguards, such as encryption, increases my risks of a privacy violation.
9. I have the right to access my medical information and obtain copies of my medical records in accordance with California law.
10. I understand that the telemedicine services provided to me will be billed to my health insurance company and that I will be billed for any patient responsibility as per my insurance.

I read and understand the information provided in this Consent to Use of Telemedicine.

Patient Name: _____ **Date of Birth:** _____

Signature: _____ **Date:** _____