ANN L. MAI, M.D.

Diplomate, American Board of Internal Medicine
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PLEASE FILL OUT AND SIGN THE BOTTOM

Name _____ □ Male □ Female
Date of Birth _____ Marital Status: □ Single □ Married □ Divorced □ Widowed
Address _____ City / State / Zip _____
Home / Cell Phone _____ Business Phone _____
Email _____ Driver's License Number _____
Social Security Number _____ Referred by _____
Employer's Name _____
Employer's Address _____

RESPONSIBLE PARTY □ **Check here if same as ABOVE**

□ Check here if same as patient information and skip to insurance information
Name _____ □ Male □ Female
Address _____
Home Phone _____ Business Phone _____
Cellular Phone _____

PRIMARY INSURANCE INFORMATION □ **Check here if same as BEFORE**

Name of Insurance Plan _____ □ HMO □ POS □ PPO □ Other
Insurance ID # _____ Group #_____
Address _____ City / State / Zip _____
Name of Insured _____ Employer_____
Date of Birth of Insured _____ SSN of Insured _____
Relationship to Patient: □ Self □ Spouse □ Child □ Parent □ Other (specify) _____

SECONDARY INSURANCE INFORMATION □ **Check here if same as BEFORE**

Name of Insurance Plan _____ □ HMO □ POS □ PPO □ Other
Insurance ID # _____ Group #_____
Address _____ City / State / Zip _____
Name of Insured _____ Employer_____
DOB of Insured _____ SSN of Insured _____
Relationship to Patient: □ Self □ Spouse □ Child □ Parent □ Other (specify) _____

EMERGENCY CONTACT INFORMATION □ **Check here if same as BEFORE**

Name _____ Relationship _____
Phone Number _____ Can we tell this person what is wrong with you? □ Yes □ No

DISCLOSURE – Please read carefully and sign.

I hereby assign my insurance benefits to be made directly to the doctor and/or his/her associates, for services rendered. I hereby attest that the above insurance information is accurate and that I am an eligible member of the stated plan. I understand that I am responsible for knowing my benefits/coverage. I will be financially responsible for all charges that are NOT covered by my insurance company. I also agree to paying all co-payments, co-insurances and/or elective service fees at the time of service. If there are problems collecting payment, attorney's fees, collection agency costs and any related fees will be added to my bill.

I authorize the release of all information other physicians and insurance carriers upon request for the purpose of payment for medical services and further treatment of care by another physician. I further agree that a photocopy of this agreement shall be as valid as the original.

I hereby acknowledge that I have read, understand and agree to hereby give consent to assess, treat and test.

Signature _____ Date _____
□ Patient □ Parent □ Child □ Legal Guardian □ Durable Power of Attorney □ Other (specify) _____

HEALTH QUESTIONNAIRE

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

Email: _____ **Mobile Number:** _____

Reason for Visit: Pap / Physical / Other _____ **Place of Birth:** _____

Current prescription medications, vitamins or supplements:

_____

Allergies: _____

PAST MEDICAL HISTORY

*Please check if **YOU** have or had (state when) the following:*

□ Measles □ Asthma □ Heart attacks
□ Mumps □ Emphysema □ Rheumatic fever / heart disease
□ Chickenpox □ Strokes □ Sexually transmitted disease(s)
□ Birth defects □ Diabetes □ Tuberculosis (TB)
□ Cancer type: _____
□ Injuries □ Broken bones details/date:_____
□ Head concussions or injuries details/date: _____
□ Hospitalization(s) _____
□ Anesthesia □ Local □ Regional □ General □ Other / Unknown
□ Operations _____
□ Car accident(s) date(s):_____
□ Other serious conditions _____

FAMILY HISTORY

*Please check if **any blood relative** has ever had:*

□ Breast cancer (who: _____) □ Colon cancer (who: _____)
□ Other cancers (_____) □ Mental illness (anxiety / depression / other)
□ Bleeding tendencies □ Osteoarthritis / Gout
□ Diabetes □ Seizures
□ Heart disease / heart attacks □ Strokes
□ High blood pressure □ Tuberculosis
□ High cholesterol □ Other _____

Relative	Age	Health Status (Excellent / Fair / Poor)	Condition(s)	Other Comments
Father				
Mother				
Sibling(s)				
Child(ren)				

SOCIAL HISTORY

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed □ Other
Are you sexually active? □ Yes □ No If yes, □ with males □ with females □ with both
Are you living with your spouse/partner? □ Yes □ No Is your sex life satisfactory? □ Yes □ No
Are there dependents at home? □ Yes □ No Children / Grandchildren / Other
Do you drink alcohol? □ Yes □ No Amount? _____
Do you smoke now? □ Yes □ No Amount? _____
Did you ever smoke? □ Yes □ No Amount / Quit date?_____
Do you use drugs? □ Yes □ No How much / often? _____
Do you have pets? □ Yes □ No Please list: _____
Do you exercise regularly? □ Yes □ No Do you have an advance directive? □ Yes □ No
Are you employed? □ Full-time □ Part-time □ Unemployed Occupation: _____
Time lost due to health reasons: In past 6 mos? _____ past yr: _____ past 5 yrs: _____

REVIEW OF SYSTEMS

*Please **CIRCLE** if you have any of the following **NOW**:*

GENERAL: Fever Chills Weight loss Weight gain Fatigue Appetite change Insomnia
SKIN: Acne Jaundice Hives Eczema Psoriasis Rashes Boils Abnormal pigmentation
HEAD/EYES/EARS/NOSE/THROAT: Headaches Eye disease or injury Glasses Contacts
Double vision Blurry vision Glaucoma Itchy eyes Runny nose Sneezing
Nosebleeds Chronic sinus trouble Ear disease Poor hearing Dizziness
NECK: Stiffness Enlarged glands Thyroid trouble
RESPIRATORY: Frequent colds Spitting up blood Cough Asthma/Wheezing Emphysema
Difficulty breathing Shortness of breath Pain with breathing Pleurisy Pneumonia
CVS: Chest pain Shortness of breath at rest / with activity Awakening in night smothering
Difficulty walking two blocks Swelling of hands / feet / ankles High blood pressure
Heart murmur Valvular heart disease Palpitations
DIGESTIVE SYSTEM: Food sticks in throat Heartburn/Indigestion Ulcer Nausea Vomiting
Vomiting blood Gallbladder disease Liver trouble Hepatitis Cramping Gas/Bloating
Diarrhea Constipation Painful stools Hemorrhoids Bloody stools Black stools
GYNECOLOGICAL: Age periods started: ____ How long do periods last? _____
Frequency of periods: Every _____ days Painful periods PMS Menopause
Birth control _____ Hysterectomy (date / reason: _____)
Number of pregnancies _____ Number of abortions/miscarriages _____
Date of last period _____ Last Pap _____ Normal / Abnormal
Date of last mammogram _____ Normal / Abnormal
GENITOURINARY: Kidney stones Loss of urine Frequent urination Burning/painful urination
Blood in urine Vaginal / Urethral discharge Circumcised? Y / N Testicular pain / swelling
MUSCULOSKELETAL: Varicose veins Weakness of muscles or joints Difficulty walking
Pain or swelling of joints Back pain (where? _____chronic? Y / N)
Scoliosis Pain in buttock/calves while walking, relieved with rest
ENDOCRINE: Thyroid disease Change in hat/glove size Hair loss Always hot / cold
Current weight _____ Current height _____ Dry skin Coarse hair
HEMATOLOGIC: Slow healing Easy bruising Anemia Phlebitis Blood Clots
NEUROPSYCHIATRIC: Lightheadedness Fainting spells Numbness Tingling Paralysis
Weakness Convulsions/Seizures Under a lot of stress Anxiety Depression Bipolar
Suicide Attempts Disinterest in usual activities Hopelessness Worthlessness
Poor concentration Anorexia Bulimia
PREVENTIVE: Last tetanus shot _____ Last flu shot _____
Last pneumonia shot _____ Last screen for colon cancer _____
Last shingles shot _____ Last prostate check / PSA _____
Name & number of your dentist _____
OTHER COMMENTS:

_____

_____

_____

Patient's signature: _____ Date: _____

Reviewed by: _____ Date: _____

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TEST RESULTS NOTIFICATION

Dear Patient,

We will notify you of your test results, including X-rays, blood work, Pap smears, etc… This process takes approximately TWO weeks. If indicated, we will contact you *sooner* by telephone regarding the results and/or follow-up instructions.

Mammogram results will be mailed directly by the radiology office, we WILL NOT email or mail out these results.

HIV results can only be obtained by making a follow up visit with the doctor. We cannot email or mail these results. This complies with California State Law. There are no exceptions.

To obtain results, please register at www.patientfusion.com and set up a new account. We will email your results through this website. WE DO NOT EMAIL TO YOUR PERSONAL EMAIL ACCOUNT!

We will also mail out results to you if you do not register, however this may take MORE TIME and you will receive your results later.

Please wait TWO (2) weeks from the date of the test performed before you contact our office for the results. Our staff is not permitted to release any results by telephone.

If you would like to discuss your results, please make an appointment with this office.

_____ I authorize my physician and/or the staff to leave messages on my answering machine, voicemail, or with a family member.

Family member to exclude: _____

_____ I request that NO messages be left at any of my numbers. I take full responsibility to make a follow up visit with this office to obtain any of my results.

Signature: _____

Print Name: _____ Date: _____

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FINANCIAL LIABILITY AGREEMENT

I understand that all co-payments, co-insurances and deductibles are due at the time of service. We do not accept a 'bill me later policy'. There are NO EXCEPTIONS.

I understand that if my insurance does not issue payment within 90 days of the date of service I will be financially responsible for the entire balance. I may pursue my insurance carrier at that time to render payment and once settled, if due, I will receive a refund for any overpayments.

I understand that it is my responsibility to inform this office of any changes in my insurance coverage. This office WILL NOT re-bill my insurance if I fail to keep the office updated with my most current insurance information. *We ask you at EVERY VISIT if there is any change, please keep us updated.*

I understand that this office DOES not verify benefits at the time of service. I am responsible for knowing my benefits and will be responsible for contacting my insurance carrier for details.

I understand that I will be financially responsible for all services rendered that are NOT covered by my insurance.

I understand that if I violate any terms of this FINANCIAL LIABILITY AGREEMENT I will be discharged from this practice and I will be financially responsible for any balance remaining on my account plus any associated collection and attorney fees.

Signature: _____

Print Name: _____ Date: _____

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Acknowledgement of Receipt of Notice of Privacy Practices

(DO NOT SIGN UNTIL YOU COME IN - OUR POLICY IS IN THE OFFICE!)

Privacy Officer: Michelle Eibl (949) 262-9700 Effective Date: April 14, 2003

Name of Patient: _____ DOB: _____

I hereby acknowledge that I received a copy of the Notice of Privacy Practices for the above physician. I further acknowledge that a copy of the current notice is posted in the reception area and that any amended Notice of Privacy Practices will be made available at my next appointment.

Signature: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

- ☐ parent or guardian of a minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient

Notice of Privacy Practices Acknowledgement Tracking Information

Complete the following only if the patient *refuses* to sign the Acknowledgement:

Efforts to Obtain: _____

Reasons for Refusal: _____

Employee Name: _____

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To Prospective and/or Our Valued Patients:

You are likely aware of the many changes that have developed over recent years to the practice of medicine. Our practice has been forced to absorb increased requirements and demands from the insurance industry that have led us to make a significant change to our practice model so we may be able to continue to offer the highest quality care possible.

We are inviting you to participate in one of our new practice models. For over 5 years, we have been offering a **Direct Primary Care** program or a **Full Concierge** program to our patients. These are limited memberships.

These changes have allowed us to offer improved access to same-day or next-day appointments, and longer visits when needed. The large number of patients in a traditional practice is reduced in this new model - so now you have Dr. Mai and our staff on a more personalized level! The **Direct Primary Care** program includes (but not inclusive of) all of the clerical fees we have previously assessed for such as medication prior authorizations, various forms, lost/misplaced orders, refills, prescriptions called in without a visit (when reasonable), e-mail access to the doctor, etc...

Our **Full Concierge** patients will benefit from enhanced communication directly with the doctor, personalized coordination of specialty referrals and hospital care, and an annual physical exam that will include nutritional counseling. Patients in our **Full Concierge** program will have FaceTime, Skype and/or Zoom access to the doctor if they are unable to come to the office.

If you are receiving this letter as an existing patient of Dr. Mai's, we ask that you decide on this offer within 30 (thirty days). Please feel free to contact us if you have any questions. We look forward to your participation and the privilege of providing you the best healthcare possible!

Sincerely,

Ann L. Mai, M.D., Staff & Affiliated Providers

Frequently Asked Questions

What is the annual fee as of January 1, 2022?
The current annual fee for the Direct Primary Care is $750 for all ages. The Full Concierge annual fee is $3,000 for all ages. Fees are subject to change without notice.

What does this fee cover?
The Direct Primary Care fee covers all of our previously assessed fees including medication prior authorizations, forms, lost orders as well as recently mandated forms for imaging and physical therapy prior authorizations. It covers services that are not reimbursed by insurance.

I am an existing patient, what will happen to me?
As an existing patient, you will be offered the first chance to sign up for membership, before any outside or new patients are enrolled. Enrollment to both programs will be limited. Signing up to be a member of the practice requires a patient application and agreement form.

What happens if I do not want to join?
ENROLLMENT IS VOLUNTARY, however, if you choose not to join, your health care will be transferred over to a medical provider of your choice, along with your medical records, with written consent to transfer your records. There will be a $50 charge to transfer records.

If I sign up with you, do I still need medical insurance?
Yes, you still need to carry insurance and we will continue to bill your medical insurance. Your normal co-payments and/or deductibles will continue to apply. This membership fee IS NOT A SUBSTITUTE FOR INSURANCE and cannot be billed to medical insurance. This fee is NOT YOUR DEDUCTIBLE.

How do I get a patient application and agreement form?
Go to **www.annmaimd.com** and download the form or pick one up from our office directly. You can fill out the form, scan it in and email it back to us too!

What are my payment options?
You may pay by cash, check, credit card, or PayPal (a link is on our website or can be sent to you). Full payment is due with the application, and will be billed annually. If we have your credit card information on file, it will be used for annual payments going forward unless you notify us otherwise. Visit **www.annmaimd.com** to pay at your convenience.

Is the annual fee tax-deductible?
If you have an HSA (health savings account) you may be able to receive reimbursement for your annual payment. Please talk to your tax advisor and/or employer about this.

What are the main differences between the $3000 fee vs the lower-fee programs?
Our $3000 patients have more prioritized access to Dr. Mai - direct access to her cell phone, email and extended office hours. Please refrain from contacting Dr. Mai directly (via text) even if you have her mobile number - this is reserved for the Full Concierge patients. She can always be reached at (949) 262-9700 24 hours a day, 7 days a week. More details can be discussed with the doctor directly.

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PATIENT APPLICATION AND AGREEMENT

_____ ("Patient") identified would like to participate in the Direct Primary Care or Full Concierge Practice ("Practice") offered by Dr. Ann Mai ("Provider"). Patient and Provider acknowledge and agree to the following terms and conditions in connection with participation in the Practice.

DIRECT PRIMARY CARE SERVICE FOR MEMBER PATIENTS

- Be a member of Dr. Mai's Internal Medicine Office in Irvine, CA
- Elimination of all previous administrative fees
- Ability to make appointments online and communicate with the office via **PatientFusion.com**
- Same day, next day appointments and/or Telehealth (eg. via Zoom)
- Medical service to coordinate Patient's complete health care needs, including prescription refills, specialty care referrals, laboratory and diagnostic imaging needs, and prior authorizations for medications or services, form fees (school physical, employer wellness programs, etc.)
- A focus on wellness through the promotion of preventive medicine and the early detection of disease - a comprehensive health assessment in addition to your annual physical

FULL CONCIERGE SERVICE FOR MEMBER PATIENTS

- All of the above benefits as above with prioritized appointments
- Personal coordination of specialty referrals and hospital care
- Annual comprehensive wellness visit to include nutritional counseling
- Direct communication with their doctor via cell phone or text messaging
- FaceTime, Skype and/or Telehealth (eg. via Zoom) access if you are unable to visit the office

PATIENT COMMITMENTS

To participate in the Practice, Patient will be required to pay an annual fee (Annual Fee) according to the following:

Annual Fee Schedule	**1 year**
Direct Primary Care	$750
or	
Full Concierge	$3,000

- The Annual Fee is for a 12 month period ("Term"). Fees are subject to increase at Provider's' sole discretion
- The Annual Fee is due on the effective date of this Agreement and on or before each anniversary thereafter as a condition for continuing as a Patient of the Practice. We will notify you of any fee increase thirty (30) days prior to your renewal
- The Annual Fee is for services that are not considered covered benefits by insurance plans or Medicare. If any of the listed services are considered covered benefits, then the Annual Fee pays for the remaining list of services
- The Annual Fee is non-refundable. Cancellation requires written notice
- If your Annual Fee is not paid within thirty (30) days of your renewal anniversary, a $200 re-instatement fee will be added upon renewal
- The Annual Fee is not reimbursable by your medical insurance as it covers non-payable expenses

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PATIENT ACKNOWLEDGMENTS

Patient acknowledges that the Practice is a unique program with certain specific limitations, including but not limited to:

- Patient has financial responsibility to pay for services that are provided at regular office visits. The Practice will bill Patient's insurance for services performed and Patient shall remain financially responsible for all charges incurred, including applicable deductibles, co-insurance and co-payments, without exception.
- In the event that Dr. Mai or Dr. Wikle is unavailable, call coverage will be provided by another physician selected and overseen by your doctor
- This Agreement shall automatically renew at the end of the existing Term. Upon expiration or termination of this Agreement, Practice will transfer Patient's medical records and continuing care to any physician requested by Patient with written notice and without charge. If you choose not to accept or renew this agreement, we will continue your care for thirty days for emergency purposes

If any provision of this agreement is held to be invalid or unenforceable in whole or in part, such invalidity or unenforceability shall attach only to such provision or part thereof and the remaining part of such provision and all other provisions hereof shall continue in full force and effect.

PATIENT ACCEPTANCE:

_____
Print Name of Primary Patient

_____
Street Address

_____ _____
Signature Date

Additional Patients:

Second Adult _____ _____
Print Name Signature

ANNUAL FEE PAYMENT INFORMATION: Total Annual Fee: $ _____

Method of Payment: ___ Check ___Visa/Mastercard/Amex

Credit Card #: _____ Exp Date: ___ /___ Security Code: _____

NOTICE OF ACCEPTANCE (to be completed by doctor):

Dr. Mai acknowledges receipt of this agreement and application to become a Patient of Direct Primary Care Program of Full Concierge Program

This agreement is effective starting _____at 12:00AM until_____ at 11:59PM

_____
Ann Mai, M.D.