ANN L. MAI, M.D.

Diplomate, American Board of Internal Medicine
4950 Barranca Parkway, Suite 207 Irvine, California, USA 92604
Phone (949) 262-9700 - (949) 262-0700 Fax
www.annmaimd.com

We are pleased that you have chosen our office for your healthcare needs. We provide all Primary Care services, including annual physicals, Pap smears, pre-op exams, adult immunizations and maintenance of chronic medical problems (to name a few...hypertension, heart, lung, brain, liver and kidney diseases, diabetes, thyroid disease, and skin disorders). As an ***Internal Medicine*** physician, Dr. Mai cares for patients over the age of 18 years. If you have any comments or suggestions, please feel free to express them to us.

Here are our policies (*please* familiarize yourself with them as it will save a lot of time and frustration should one or more of these situations arise). Our membership patients (Direct Primary Care and Full Concierge patients) enjoy our practice without any of these fees or time limitations.

Office hours: 8am to 5pm, Monday through Thursday. On Fridays 8am to 4:30 pm. Our office is open throughout the lunch hour for appointments but the phones are rolled over to an answering service. Physician hours may vary.

Messages to the physician: We attempt to answer all calls by the end of the day. Please let us know if your call is urgent and needs immediate attention. You may reach the doctor directly for non-urgent issues via e-mail by registering at www.patientfusion.com There may be a fee for this service. **Do not** e-mail and call in your message at the same time. This causes confusion and will further delay our response time.

Telephone treatment: For our patients who are too busy to come in, it is possible in some circumstances to prescribe over the phone. There is a **$20 administrative charge** for this service as it involves the doctor taking time out of her schedule to address this immediately and staff time to coordinate treatment with the patient. To avoid this charge, you may come in for an appointment in this office.

Medication refills: Please contact your pharmacy to fax your request to **(949) 262-0700**. Refills take approximately **48-72 hours** to process. There is a **$20 charge** for rush / urgent prescription refills. You are responsible to know when you run low on pills and we do not keep track of this. You are welcome to come in for an appointment to refill medications. Do not request refills at the pharmacy and www.patientfusion.com at the same time; this will result in further delays.

Test results: Please allow **TWO weeks** after you have completed the test(s) to receive the results via US mail. If you are registered at www.patientfusion.com, results will be posted in about **ONE week**. **Do not** call the office for results unless you have waited the TWO weeks. We will call you if there are concerning results. If you would like to discuss test results with the doctor directly, please make an appointment. **The staff is not permitted to give out test results over the phone**.

Appointment Policy: There is a **$50 charge** for missed appointments. We make every effort to accommodate you for a same-day appointment if your problem is urgent. You will be seen by the doctor, but there may be extra waiting time. Please note that these appointments are not for add-on non-urgent problems. We cannot accommodate every patient who says. "By the way..." or "While I have your attention..." or "Can you *also* look at this and do that?" One day you could be that patient waiting on the other end! Our cancellation policy is **24 hours.**

Referrals: For our HMO patients, referrals not processed at the time of the visit will be mailed to you by your insurance plan within TWO weeks. Please call our office if you do not receive the paperwork. For our PPO patients, it is your responsibility to know your benefits and when pre-authorization is needed for tests/procedures/referrals. **We do not process retro-authorizations**.

Forms: An administrative fee of **$35.00** will be assessed **for every form** that requires the doctor's signature, exclusive of prescriptions and State of California disability forms. We will not release the form(s) until the fee is received. Forms include and are NOT limited to: prescription prior authorization forms, work/school/camp/sports/insurance physical forms, work/school time off notes, disability extension notes/forms, DMV forms, life/health/disability insurance forms, private/work disability forms, prescription assistance program forms, and any certificates of current medical status.

Lost paperwork: An administrative fee of **$35.00** will be assessed to replace all paperwork (test orders, letters, forms…) that you have misplaced.

After hours: A physician is **ALWAYS on-call** after hours and on weekends for URGENT MEDICAL ISSUES. You may page the doctor by calling our office at **(949) 262-9700**. Please contact our office prior to seeking care elsewhere whenever possible. **HMO patients must have authorization PRIOR** to going to urgent care or the emergency room. **HMO patients** may only use **Hoag Hospital** and certain designated urgent care centers; using other facilities will result in unexpected medical bills. Again, this policy applies 24 hrs/day, 365 days / year. See www.GNPweb.com for a list of approved urgent care centers for HMO patients.

Billing policy: It is customary to pay all deductibles, co-insurance, and/or co-payments **at the time of service**. It is illegal for us to waive these charges. If your insurance cannot be verified at the time of service, you may reschedule your appointment or make full payment and a refund will be issued after the claim is billed and paid. It is your responsibility to know your benefits and bring proper valid documentation. We are unable to verify benefits due to time constraints; our billing company is off-site. Please review the FINANCIAL LIABILITY WAIVER for details.

For life-threatening emergencies, call 9-1-1.

ANN L. MAI, M.D.

Diplomate, American Board of Internal Medicine
4950 Barranca Parkway, Suite 207 Irvine, California, USA 92604
Phone (949) 262-9700 - (949) 262-0700 Fax
www.annmaimd.com

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: _____

Ann L. Mai, M.D. - Diplomate, American Board of Internal Medicine
4950 Barranca Parkway, Suite 207 Irvine, CA 92604 www.annmaimd.com

ANN L. MAI, M.D.

Diplomate, American Board of Internal Medicine
4950 Barranca Parkway, Suite 207 Irvine, California, USA 92604
Phone (949) 262-9700 - (949) 262-0700 Fax
www.annmaimd.com

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: _____

ANN L. MAI, M.D.

Diplomate, American Board of Internal Medicine
4950 Barranca Parkway, Suite 207 Irvine, California, USA 92604
Phone (949) 262-9700 - (949) 262-0700 Fax
www.annmaimd.com

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: _____

ANN L. MAI, M.D.

Diplomate, American Board of Internal Medicine
4950 Barranca Parkway, Suite 207 Irvine, California, USA 92604
Phone (949) 262-9700 - (949) 262-0700 Fax
www.annmaimd.com

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: _____