8733 Beverly Blvd., Ste 408, West Hollywood, CA 90046
6801 Park Terrace Drive, Ste. 330, Los Angeles CA 90045
t: 310-295-2255 // f: 310-657-4950

Name: _____ **DOB:** _____ Gender: Male / Female

Address: _____ City: _____ State: _____ Zip Code: _____

Home Tel: _____ Mobile: _____ Email: _____
By providing this you authorize text, email communication from our office

Ethnicity: American Indian / Asian / Black/African American / Hispanic / White /Other:_____
Prefer Not to Answer

Marital Status: Single / Married / Separated / Widowed / Divorce

SSN: _____-_____-_____ Pharmacy:_____

Employer: _____ Tel: _____

Medical Insurance: _____

Address: _____City: _____State: _____ Zip Code: _____

Emergency Contact:

Name: _____ Tel: _____ Relationship: _____

Allergies:
_____

If applicable:
Attorney Name: _____ Phone: _____

Date of Injury: _____ Claim No.:_____

*Note: Your insurance is a contract between you, your employer and the insurance company. We are NOT a party to that contract.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. There will be a 1.5% interest charge per month and a 30% collection fee for overdue accounts. I have read all the information and have completed the above answers. I certify this information is true and correct to the best of my knowledge.

Dr. Aggarwal may refer you to receive services from Kansal, Inc., a professional medical corporation in which Dr. Aggarwal has an ownership interest. Dr. Aggarwal may refer you to Kansal based in his sound medical judgment and his first-hand knowledge of the excellent healthcare professionals affiliated with Kansal. It is important for you to know that Dr. Aggarwal will not receive anything in return for referring you to Kansal, and you are free to choose any other physician or medical corporation to meet your health care needs.

Signature_____ Date_____

PLATINUMCARE LA
where every patient is our VIP

HIPAA Information and Consent

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 1, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. WE balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the US Department of Health and Human Services via www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, and health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information, which is not already a matter of public record. The normal course of providing care mans that such records may be left, at least temporarily, in administrative areas such at the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, US Mail, or by any means convenient for the practice and as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient

9. You have the right to request restrictions in the use of your PHI and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Patient Name _____

Signature _____ Date_____

Authorization for Use / Disclosure of Health Information

Authorization to release the protected health information of:

Patient Name:_____ DOB:_____ SSN:_____
Current Address:_____City:_____Zip:_____

This Authorization is to release protected health information to:

Facility/Provider:_____Fax:_____Tel:_____
Address:_____City:_____Zip:_____

This Authorization is to release protected health information from:

Facility/Provider:_____Fax:_____Tel:_____
Address:_____City:_____Zip:_____

Purpose: I authorize the release of my health information for the following specific purpose:

_____.
Note: "at the request of the patient" is sufficient if the patient is initiating this authorization.

Information to be disclosed:

I authorize the release of the following health information: (check the applicable box below)

- ❑ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.[1]

- ❑ Only the following records or types of health information:
  _____.

Term: I understand that this Authorization will remain in effect:

- ❑ From the date of this Authorization until the _____ day of _____, 20_____.
- ❑ Until the Provider fulfills this request.
- ❑ Until the following event occurs:
  _____

Redisclosure: I understand that my healthcare provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and
state law governing the use and disclosure of my health information.

[1] **NOTE: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by the Lanterman-Petris-Short Act.**

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at PlatinumCare LA. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to PlatinumCare LA. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my healthcare provider in reliance on this Authorization before it received my written notice of revocation.

_____	_____	_____
Signature	Date	Signature of Witness

If Individual is unable to sign this Authorization, please complete the information below:

Name of Guardian/ Representative: _____

_____	_____	_____
Signature	Date	Signature of Witness