Lesley J. Anderson, MD
New Patient Information

Name: _____ **DOB:** _____ **Age:** _____ **Sex:** _____
(Last) (First) (MI)

Address: _____ **Apt:** _____

City: _____ **State:**_____ **Zip:** _____

Cell Phone #: _____ **Last 4 of SSN:** _____ **Marital Status:** _____

Home Phone #: _____ **E-Mail:** _____

Employer: _____ **Occupation:** _____

Work Phone #: _____ **Work Address:** _____

Spouse/DP/Other Contact: _____ **Phone #:** _____

Primary Care Dr.: _____ **Address:** _____

Phone #: _____ **Fax #:** _____

Referred By: _____ **Reason For Visit**: _____

Date of Injury or Onset: _____ **Type of Injury: Auto**____ **Sports**____ **Work** ____ **No Specific Injury**___

INSURANCE CARD REQUIRED AT THE TIME OF VISIT

Primary Insurance: _____ **Phone #:** _____

Address: _____

Insured Name: _____**ID #:** _____ **Grp #:** _____

Secondary Insurance: _____ **ID #:** _____

FOR WORK RELATED INJURY/COMPENSATION ONLY

WC Carrier: _____**Adjuster:** _____

Address: _____ **Phone #:** _____

Date of Injury: _____ **Claim #**_____ **Fax #:** _____

Case Manager: _____ **Phone #:** _____ **Fax #:** _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to LESLEY J. ANDERSON M.D. of the surgical and/or medical benefits, if any, otherwise payable to me for services rendered to me or my dependent. I also authorize my doctor to release information regarding my treatment to secure such payment. I understand I am financially responsible for all charges. If a referral slip is required from my health plan or HMO/PPO, I agree to furnish this to Lesley J. Anderson M.D. and I will be financially responsible for my doctor's visit.

SIGNATURE: _____ DATE: _____

LESLEY J. ANDERSON M.D.

- **MEDICATIONS:** please list the medications you are currently using (use other side if needed):

- **ALLERGIES TO MEDICATIONS**: _____

_____

RISK FACTORS	**RACE CHOICES**	**ETHNICITY CHOICES**
☐ Current, daily smoker	☐ American Indian	☐ Hispanic
☐ Current, sometime smoker	☐ Asian	☐ Non-Hispanic
☐ Smoker, status unknown	☐ Black	☐ Unknown
☐ Never smoker	☐ Native Hawaiian	
☐ Former smoker	☐ White	
☐ Unknown if ever smoked	☐ Unknown	

Do you drink alcohol daily? Y / N	Do you exercise daily? Y / N	Do you drink caffeine? Y / N

- **GENERAL HEALTH:** please mark if you have a history of any of the following:

☐ High blood pressure	☐ HIV	☐ Arthritis	☐ Sinus disease
☐ Heart attack/Angina	☐ Cancer	☐ Prior severe injury	☐ Tuberculosis
☐ Thyroid disease	☐ Hepatitis	☐ Neuro problem	☐ Wt. loss/fevers
☐ Bleeding problem	☐ High cholesterol	☐ Anesthesia problems	☐ Hx of sexual abuse
☐ Diabetes	☐ Stroke	☐ Lung disease	☐ Check if pregnant

Other serious illnesses: _____

_____

- **PRIOR SURGERY:** _____

- **FAMILY HISTORY:** do you have a family history of:

☐ Heart disease	☐ Diabetes	☐ High blood pressure	☐ High cholesterol
☐ Colon cancer	☐ Breast cancer	☐ Osteoporosis	☐ Stroke

Detail: _____

- **PREFERRED PHARMACY:**

Pharmacy Name:_____

Address:_____

(Street) (City) (State) (Zip)

Phone Number: _____

_____ _____

Signature Date

LESLEY J. ANDERSON M.D.

WELCOME TO OUR OFFICE!

Please take a moment to review our office polices.

_____ Initials
Our office will bill your insurance company for services performed in our office. **You are responsible for any deductibles or co-payments.** Copays are **due at the time of your office visit.** We do our best to assist you in authorizations and benefits. But it is important to remind you that it is your responsibility to know and understand the policies and benefits for your insurance plan.

_____ Initials
Any cancellation must be made at least 48 hours in advance. It is our policy to charge $75 for cancellations made within 48 hours or missed appointments. You will be responsible for paying the missed appointment fee regardless of your insurance coverage. This includes Workers Compensation patients. Your insurance will not pay this fee.

_____ Initials
Our office provides telemedicine appointments in lieu of in-office follow ups in selected situations. If you chose this option, you are consenting to telehealth services and understand that co-pays will be due at the time of the appointment.

_____ Initials
Many of you may have disability insurance forms. We **require five working days** to fill these out as the forms often take substantial amounts of time to complete. There is a **$40 charge for private disability forms** (ie: Aflac, Colonial) and a **$20 charge for State Disability (EDD)**. This is to **be paid in advance** at the time the forms are dropped off. If **medical records** are requested, there is a **$0.25 per page charge**. This is not billed to your insurance company.

_____ Initials
We will be able to provide a one time copy of your medical records provided that the records are fewer than 50 pages. If the **records exceed 50 pages**, there will be a charge **of $30 each time records are requested**, to cover the cost of time and materials. Five working days are needed for completion of your request. There is an additional $10 fee if the records need to be rushed or completed with 24 hours. To protect your privacy, no records will be released without your written consent.

Patient Disclosure

California Law imposes disclosure requirements for Physicians that have a financial interest in a facility to which they refer patients. In compliance with the law, please be advised that if you need surgical treatment, Dr Anderson has a financial interest in the Pacific Heights Surgery Center of San Francisco, where your surgery may be performed. If you prefer that your surgery NOT be performed at Pacific Heights Surgery Center, please let our office know so that we can make other arrangements for your surgery.

Federal Law imposes disclosure requirement of Physicians to inform patients in writing that patients may obtain MRI, CT or PET scans from a person or facility other than the locations the referring physician may suggest. Our office will provide you with a list of providers in the area where you reside if requested.

By signing below you acknowledge that you have read and understand the above.

_____
Print Name of Patient

_____ Date _____
Signature of patient or patient's representative

2100 Webster St. Suite #309 San Francisco CA 94115 (415) 923-3029 Fax (415) 345-9319

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:_____ Signature_____Date_____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and 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.

Thank you for being one of our highly valued patients.

Lesley J. Anderson, M.D.

Surgery of the Knee & Shoulder
Orthopaedic Surgery

Consent for Disclosure to Family Member and/or Personal Representative

Please complete this form if you wish to give authorization for our office to speak with anyone other than yourself regarding your care with our office. HIPPA requires our office have written consent from a patient before medical information is given to anyone not involved in the patient's care for purpose of treatment or billing. If there are no individuals you give permission to disclose your medical information to, cross out the fields below.

I agree to allow the following individuals to receive information related to my medical care. Therefore, I give my permission for Lesley J. Anderson MD and the staff to disclose my personal medical information to the following individual(s).

Name: _____Relationship to Patient: _____

Phone #: _____Email Address: _____

Name: _____Relationship to Patient: _____

Phone #: _____Email Address: _____

Consent to Leave Medical Information on Voicemail or E-mail

The practice may leave test results and information regarding my care by voicemail at this phone number: _____.

The practice may send information regarding my test results and information regarding my care to the following email address: _____.

I consent to receive calls from Lesley Anderson, MD for my protected healthcare and other services at the phone number(s) above, including my wireless number provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

I understand that this consent may be revoked by me at anytime by written notice to the practice. I am aware that a copy of this signed disclosure will be kept as part of my medical record.

_____
Patient Name

_____ _____
Signature of patient or patient's representative Date

LESLEY J. ANDERSON M.D.

Telehealth Appointment Consent Form

This consent is for all telehealth services provided to me by Dr. Lesley Anderson.
Telehealth is the use of the Internet to provide remote health care for patients.
Specifically, Dr. Anderson will be communicating with me remotely.
This telehealth appointment may be for diagnosis, continuity of care, treatment, testing, or medical consultation deemed necessary by Dr. Anderson or me.

I understand that during a telehealth appointment:

- Details of my medical history and health info. may be discussed with me and/or other health professionals;
- Audio, video, or photo recording containing medical details may be transmitted via secure channels and those details may become part of my permanent medical record;
- All confidentiality protections granted to me by various state and federal laws apply to this appointment;
- Industry-standard network and software security protocols are in place that protect the privacy of the communication and safeguard my transmitted information against eavesdropping and corruption;
- There may be security and privacy risks associated with Internet-based communications;
- There are benefits and limitation when compared to a traditional in-person visit due to the fact that I will not be in the same room as my healthcare provider;
- Either my Healthcare Provider or I can discontinue the Telehealth Appointment if either of us feels that the information obtained through remote communications is not adequate for diagnostic decision-making or for providing the care I desire;
- In addition to my Healthcare Provider named above, I will be informed of any other person(s) who may be present during the appointment and have the right to have them leave the viewing and listening area;
- To maintain my privacy, I need to ensure that my viewing and listening area is limited to myself and any other person that has a need to participate during the visual appointment;
- I have the right to omit or withhold specific details of my medical history/physical examination that are personally sensitive;
- My healthcare provider may advise me to seek immediate treatment or determine that there is a medical emergency and, as such, local authorities may be given my personal details to assist me;
- The communication is privileged and confidential, and I will not record the audio or video without first seeking the permission of my Healthcare Provider.

Therefore, by consenting to Telehealth Appointments:

1. I desire to engage in remote audio-visual communication with my Healthcare Provider.
2. I understand the risks and benefits of using Internet-based communications and that no results can be guaranteed.
3. I acknowledge that if the Healthcare Provider believes that remote communication is insufficient for treatment, consultation or evaluation, then I will be offered alternate services or options.
4. I understand that I may be responsible for copayments, deductibles or other charges from my healthcare provider and additional charges may occur for services related to this appointment.
5. I have the ability to ask direct questions to my Healthcare Provider about this appointment, including details about the Healthcare Provider's privacy policy.
6. If my questions were not answered to my satisfaction, I have the right to terminate the appointment.
7. I am at least 18 years of age.

My preferred method of contact for Telemedicine appointments is *(please check one)*:

❑ **Doxy.me (invite via email/text)** ❑ **FaceTime** ❑ **Zoom (invite via email)**

_____ _____
Print Name of Patient Cell Phone #

_____ _____
Signature of patient or patient's representative Date

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